STANDING COMMITTEE ON PUBLIC ACCOUNTS

Hansard Verbatim Report

No. 16 — June 4, 2026

Published under the authority of The Hon. Todd Goudy Speaker

Legislative Assembly of Saskatchewan

Thirtieth Legislature

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

Trent Wotherspoon, Chair
Regina Mount Royal

James Thorsteinson, Deputy Chair
Cut Knife-Turtleford

Terri Bromm
Carrot River Valley

David Chan
Yorkton

Hugh Gordon
Saskatoon Silverspring

Travis Keisig
Last Mountain-Touchwood

Joan Pratchler
Regina Rochdale

[The committee met at 09:00.]

Chair Wotherspoon: — Well good morning, everyone. We'll convene the Standing Committee on Public Accounts. My name is Trent Wotherspoon. I'm the Chair of Public Accounts. I want to welcome everyone that's joined us here today.

I'll start with introducing the committee members that have joined us: Deputy Chair Thorsteinson, MLA [Member of the Legislative Assembly] Keisig, MLA Gordon, MLA Pratchler; MLA Crassweller is substituting for MLA Chan. And I think we might have another substitution coming along here in a bit but not here at this point. We'll introduce them when they join us.

I'd like to welcome and introduce our officials with the Provincial Comptroller's office. I see a member with their hand. I'm going to come back to you to see what's up as soon as I'm done introducing the comptroller and the auditor's office.

So we have the Provincial Comptroller, Brent Hebert, that's here with us today, as well as Jane Borland, assistant provincial comptroller. I'd of course like to welcome and introduce our Provincial Auditor, Tara Clemett, and to welcome her officials that have joined us here today and all those involved in the work. I know as we go she'll be introducing her officials as it pertains to each of the relevant chapters.

And I'll come over to MLA Gordon, who's signalling that he has an intervention.

Hugh Gordon: — Thank you, Mr. Chair. I appreciate the opportunity here. I'd like to present a motion to this committee, and a very important motion with respect to the government's plans for the coal refurbishment at SaskPower.

I think we can all agree that on this committee, it is our job and it is our duty to ensure that government is a good steward of public tax dollars, that the plans that the government has initiated, you know, can survive scrutiny, that are above board, that there is a level of transparency and accountability with the way that they shepherd public funds. And that their plan for the coal refurbishment in the province through SaskPower is done in an insightful way, is done in an effective way, is done in an efficient way. And that the public can rest assured that those plans and the costing for those plans is well based, that we can have confidence in that decision and that going forward the people of the province have confidence in SaskPower and all the ancillary fallout from that decision.

So I would ask to move the following motion:

> That the Standing Committee on Public Accounts, pursuant to subsection 16(1) of *The Provincial Auditor Act*, request that the Provincial Auditor perform a special assignment investigation to examine the increase in projected costs of the government's coal refurbishment plan from 900 million to $26 billion.

And I would also ask, Mr. Chair, for a standing vote on that as well.

Chair Wotherspoon: — Just a point of clarification. The term "standing vote," would interpret that as a recorded vote. Is that what you're looking for? So I guess I'd look to . . . I'd welcome as well, we have another committee member that's joining us here: MLA McLeod, who's substituting for MLA Bromm here today. So welcome, MLA McLeod.

We have a motion that's been moved by MLA Gordon. I'll read that motion:

> That the Standing Committee on Public Accounts, pursuant to subsection . . . of *The Provincial Auditor Act*, request that the Provincial Auditor perform a special assignment investigation to examine the increase in projected costs of the government's coal refurbishment plan from 900 million to $26 billion.

So my question is, is the committee ready for the question? Or is there further debate? MLA Keisig.

Travis Keisig: — Thank you, Mr. Chair. I'd just like to put a few comments on the record. The committee had no clue this motion was coming forward. This concern has been debated wildly in the Legislative Assembly, and I do not believe it is relevant to the purview of the committee's work today. So I will not be supporting this motion.

Chair Wotherspoon: — Any other comments, or is the committee ready . . . Or debate? Is the committee ready for the question?

Some Hon. Members: — Question.

Chair Wotherspoon: — Question. Is it the pleasure of the committee to adopt the motion?

Some Hon. Members: — Agreed.

Some Hon. Members: — No.

Chair Wotherspoon: — Okay. I hear a couple "agreeds." I hear some nos. And there's been a recorded vote that's been requested. So I'd ask all those in favour . . . I'd remind folks too that the Chair would vote in the event of a tie. But the protocol is, the procedure otherwise is for the Chair not to vote.

All those in favour of the motion, please raise your hand. Just because I saw a few different hands going up around both sides there, I'll just make sure I ask again. All those in favour, please raise your hand. Okay. Two.

All those opposed to the motion, please raise your hand. Looks like four to me, Clerk.

Those in favour of the motion, two. Those opposed to the motion, four. I declare that the motion is lost.

Saskatchewan Health Authority

Chair Wotherspoon: — Okay, folks. We've introduced the comptrollers, the Provincial Auditor's office. I'd like to announce at this time our first agenda items and our focus here today, which are going to be on the Saskatchewan Health

Authority. I want to thank the officials that have joined us here today and all those involved in the work that's going to be considered here today.

I'd invite at this point ADM [assistant deputy minister] O'Neill, who's seated at the middle of the table, to introduce all the officials that have joined him here today. Refrain from getting into the respective chapters at this point. I'll turn it over to the auditor for presentation then come back your way for comments at that time.

So, ADM O'Neill, thanks for being here, and please introduce your officials.

Norman O'Neill: — Thank you, and good morning to everybody. Just some quick opening remarks. So I'll just thank the Provincial Auditor of Saskatchewan, Tara Clemett, and her team for joining us today. We acknowledge the important role that the Provincial Auditor plays in providing independent oversight for the Ministry of Health and our partner agencies.

We're joined today by staff from the Ministry of Health and the Saskatchewan Health Authority to discuss progress on the previous auditor's reports and to address any follow-up questions. Myself, I am Assistant Deputy Minister Norm O'Neill from the Ministry of Health. Joining me from the ministry today are James Turner, assistant deputy minister; Chad Ryan, assistant deputy minister; David Matear, assistant deputy minister; Ryan Dobson, director of operations and internal audit; and Monifa Minott, manager of internal audit.

Additionally, from the Saskatchewan Health Authority the representatives include Andrew Will, to my left, who's the chief executive officer; Julia Pemberton, to my right, who's the vice-president of integrated northern health; Derek Miller, chief operating officer; Carla Male, vice-president of finance and chief financial officer; and Mike Northcott, chief human resources officer.

The Ministry of Health and the SHA [Saskatchewan Health Authority], along with our partners, value the work of the auditor as I've noted, and we value the recommendations found in these reports. Work is ongoing to strengthen programs, processes, and outcomes. And we'll build on today's review and discussions. We remain focused on strengthening accountability, improving patient safety, and ensuring Saskatchewan residents receive high-quality care. We continue to put patients first in everything we do.

The ministry and our health system partners share the same objective as the Provincial Auditor, which is to support continuous improvement and ensure effective stewardship of public resources in delivering health services. We look forward to today's discussion and the opportunity to review these important reports. And that concludes my comments and introductions.

Chair Wotherspoon: — Okay, well thanks so much for being here and for those remarks and your introductions. I'd like to thank the folks as well that were involved in putting together the status update that was supplied to the committee that focused on each of the recommendations. That certainly allows committee members to focus their questions. And at this time I'll table that document, PAC 94-30, Saskatchewan Health Authority: Status update, dated June 4th, 2026.

I'm going to turn it over now to our Provincial Auditor. She'll introduce the officials that have joined her here and then focus in on the first chapter for consideration and the new recommendations that come from it. The first focus will be from the 2025 report volume 1, chapter 6. And I'll kick it over to Provincial Auditor Clemett.

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 portfolio of work that does include the Saskatchewan Health Authority. And behind him is Ms. Kim Lowe, and she would have been involved in a number of audits that we'll be discussing today. And she's acting as our liaison with the committee as well today.

Jason and I are going to present the chapters for the Saskatchewan Health Authority in the order that they do appear on the agenda. That will result in 10 separate presentations. We will pause for the committee's discussion and deliberation after each presentation. There are two presentations that do include 11 recommendations that are new for the committee's consideration and eight presentations that are follow-up audits, and they provide a status update on outstanding recommendations the committee has already previously agreed to.

I do want to thank the CEO [chief executive officer] of the Saskatchewan Health Authority and all his officials for the co-operation that was extended to us during our work.

With that I'm going to start as indicated with chapter 6 that is first on the agenda. Chapter 6 of our 2025 report volume 1 reports the results of our audit of the Saskatchewan Health Authority's processes to deliver opioid addiction treatment services for the 12-month period ended December 31st, 2024. We concluded the Authority had effective processes other than the areas reflected in our eight recommendations.

In 2023, 341 people died from opioid drug toxicity in Saskatchewan. Opioid use disorder and addiction is where individuals find it hard to control the use of opioids. Opioid use disorder can be managed by using medication combined with counselling and behaviour therapies.

Opioid agonist therapy, also referred to as OAT, is a medication-assisted treatment for people with opioid use disorder to reduce their cravings for opioids and prevent withdrawal symptoms. Additionally rapid access to addictions medicine, also referred to as RAAM, services can provide quick access to care for those struggling with opioid use disorder by connecting clients to appropriate community health care providers for ongoing care and support.

In 2024-25 the Saskatchewan Health Authority budgeted over $306 million on mental health and addictions services, including $4.6 million specifically related to out-patient clinics providing OAT and RAAM services to clients with opioid use disorder. These clients may also be referred to in-patient services for treatment in a structured, substance-free, live-in environment.

[09:15]

At the time of our audit, the Authority operated 13 OAT out-patient programs in 11 communities along with RAAM out-patient clinics located in four communities. Additionally the Authority operated 12 in-patient addiction treatment facilities across Saskatchewan where it directly provided treatment services to clients.

We made eight recommendations to strengthen the Authority's treatment services, and I'm now going to walk you through each of them.

On page 79 we recommend the Saskatchewan Health Authority provide clear and easily accessible information to the public about opioid addiction treatment services available in the province.

The Authority uses its website along with the Government of Saskatchewan's website to inform individuals about opioid use disorder and addiction treatment services. We found these websites were difficult to navigate, which may result in unnecessary complications for someone searching for where and how to get help for opioid use disorder — for example, clinic location, operating hours.

Our review of websites maintained in other jurisdictions like Alberta and BC [British Columbia] found they included better information about different treatment options, clinic details, helplines, and online appointment booking.

In addition, while we found some out-patient clinic staff periodically met with community-based organizations to increase the awareness of opioid addiction treatment services available, we found that the Authority did not use formal communications, like pamphlets or posters within shelters and emergency rooms, to make individuals aware of available opioid addiction treatment services. A lack of clear and easily accessible information about available opioid addiction treatment options can prevent individuals and their families from finding appropriate help and resources when needed.

On page 81 we recommend the Saskatchewan Health Authority analyze the provincial supply and demand for its opioid addiction treatment services.

The Authority separates the operational responsibility for its opioid addiction treatment services across the province between two units, and it does not have a central IT [information technology] system tracking addictions treatment. This limits the Authority's ability to have aggregated and comparable data for assessing supply and demand for the addiction treatment services it provides.

We visited six addictions treatment facilities and found staff address fluctuations in demand on an ad hoc basis by reallocating existing funding within their budgets or communicating with the Authority's management about the needs for further resources like additional staff. As the Authority did not analyze supply and demand for opioid addiction treatment services across the province, we analyzed available data to identify circumstances that may warrant further analysis by the Authority. We found it reasonable that the Authority had varied opioid treatment services — so out-patient and in-patient — in Saskatoon and Regina, as this is where most opioid overdose hospitalizations and drug toxicity deaths do occur.

However we found differences in prescriber availability within Regina and Saskatoon OAT programs, highlighting a need for further analysis. Regina clients waited fewer days to receive treatment in 2024, an average of 1.75 days, compared to Saskatoon clients, who waited an average of 4.75 days. Lack of analysis of supply and demand for opioid addiction treatment services increases the risk of the Authority not having treatment available to clients where needed.

On page 84 we recommend the Saskatchewan Health Authority implement standardized approaches — so work standards and IT system — for its opioid addiction treatment services across the province.

As I mentioned, the Authority separates the operational responsibility for its addiction treatment services across the province between two units, and it doesn't have a central IT system associated with addictions treatment.

We also found each of the Authority's out-patient opioid addiction treatment facilities maintain their own work standards guiding the services that they provide, like intake assessments and treatment plans. A review of the work standards for three out-patient clinics we visited found one facility's standards aligned with good practice, but two of the facilities' standards did not include guidance about a client's continuum of care, such as referrals to other services, as expected.

We also found inconsistencies in the requirements for assessing clients' withdrawal symptoms. Authority management indicated that it does expect to develop a provincial OAT program including work standards applying to all facilities by 2028.

Without provincial standards there's an increased risk of the Authority providing inconsistent treatment services to clients. Additionally one IT system for delivering opioid addiction treatment services would enable the Authority to have a complete picture of opioid addiction treatment services throughout the province.

On page 86 we recommend the Saskatchewan Health Authority consistently assess opioid withdrawal symptoms before prescribing OAT medication to clients receiving out-patient opioid addiction treatment services.

Out-patient opioid addiction treatment services are guided by established guidelines. The guidelines set out key assessments and tests health care staff must complete before prescribing clients OAT medications, for example, methadone. Key assessments include intake assessments such as medical and substance use history, urine drug tests, and opioid withdrawal symptom assessments such as assessing a client's resting pulse rate or their irritability.

We tested 30 client files and found staff completed intake assessments as well as urine drug tests for all clients prior to the physicians prescribing OAT medication. However we did not find evidence of staff providing opioid withdrawal assessments for 16 clients. Not consistently performing and documenting

opioid withdrawal assessments limits the health care staff's ability to determine a client's level of opioid dependence to help determine the right time to start the client on medication.

On page 87 we recommend the Saskatchewan Health Authority provide timely out-patient opioid addiction treatment services, so the initial treatment and follow-up to clients with opioid use disorder. When a staff at an out-patient facility assesses a client as having an opioid use disorder, good practice recommends the client have access to a physician or a nurse practitioner to be prescribed OAT medication within a maximum of three days of the assessment. Once clients receive a prescription for OAT medication, guidelines expect health care staff to reassess the clients within three days of the first dose of Suboxone, and at least once a week for the first 14 days of prescribing methadone.

Our testing of 30 client files found the average wait time to see a health care professional for the initial OAT medication prescription was 3.5 days in 2024. Two out-patient facilities have an average wait time of 4.0 and 4.7 days, which is beyond the recommended good practice of three days.

Additionally we found health care staff did not reassess 11 clients we tested within prescribed time frames. For example, staff provided one client with a six-month supply of methadone but had not scheduled follow-up appointments during this time to assess the effectiveness of the treatment.

Not having OAT medication within three days delays the ability for a client to start the recovery process, and long waits increase the risk of a client not returning to a clinic. Not reassessing clients after the first dose, as required by the guidelines, increases the risk that the client's response to the medication is not monitored and treatment is not adjusted as necessary.

On page 88 we recommend the Saskatchewan Health Authority consistently complete discharge transfer plans for clients receiving in-patient opioid addiction treatment services. Guidelines set out a minimum standard of care for in-patient addiction treatment facilities to ensure service quality is consistently delivered across the province. We tested files for six in-patient clients with opioid use disorder and found the Authority maintains appropriate documentation of the requirements set out in the guidelines such as client history, medical examinations, establishment of recovery goals, except for discharge or transfer planning.

One in-patient facility did not maintain evidence of discharge or transfer planning for two of three client files that we tested from that facility. Discharge or transfer planning encourages a collaborative approach between the client, the in-patient facility case manager, and the community case manager to support a client's successful long-term recovery.

On page 89 we recommend the Saskatchewan Health Authority offer opioid agonist therapy medications to clients with opioid use disorder while receiving social detox services. Good practice recommends individuals with opioid use disorder not be offered withdrawal management detox alone. Research shows clients going through detox without transitioning to an OAT program may experience increased risks of relapse, lower rates of retention in treatment, and higher rates of illness or death.

We tested six clients with opioid use disorder who attended an in-patient treatment facility for social detox, and found four were not receiving OAT medication while in social detox. While these clients received medical assessments prior to admission into the facility, we found that facility staff did not offer OAT medication as an option for these clients. Not providing OAT medications to clients with opioid use disorder while receiving detox services increases the risk of relapse, illness, or death.

On page 92 we recommend the Saskatchewan Health Authority consistently track and analyze and report key performance information related to delivering opioid addiction treatment services in the province. The Authority's out-patient and in-patient facilities track various ad hoc information about addiction treatment services, but staff track information inconsistently between facilities. We found each facility uses the information collected for its own internal purposes. Information is not reported to senior management, and the Authority doesn't use it to assess performance of its opioid addiction treatment services across the province, such as whether services are meeting client demand.

Each quarter the Authority provides the Ministry of Health with wait time reports for the four most active OAT programs in Kamsack, Prince Albert, Regina, and Saskatoon. However we did find the reports unreliable, as we found errors and inconsistencies. For an example, an OAT program calculated wait times in one instance using business days, and another one used calendar days. And it is recommended good practice to use calendar days. Additionally we found the reports only considered new starts and did not consider wait times for clients that were restarting their OAT treatments.

We also found the Authority doesn't track and analyze or report other key information to senior management related to the delivery of opioid addiction treatment services in the province. Our chapter includes a number of potential key performance indicators related to OAT programs that the Authority may want to consider implementing, such as the number of individuals entering the health system with opioid use disorder and the number of clients receiving OAT each month or for the first time. Without consistently tracking, analyzing, and reporting key information, the Authority is unable to sufficiently analyze trends and assess whether its opioid addiction treatment services meet clients' needs and are having impact.

I will now pause for the committee's consideration.

Chair Wotherspoon: — Thank you, Auditor. Certainly is an incredibly important focus with your work in the chapter here and the recommendations before us. These are new recommendations, so I'll turn it over to ADM O'Neill to provide some brief remarks on those recommendations. Of course we've received the status update as well. And then we'll open up for questions.

Norman O'Neill: — So thank you. So regarding the recommendation for the SHA to provide clear and easily accessible information to the public, the SHA has updated its public-facing website listing opioid agonist therapy, or OAT, clinics across the province. This enhances clarity and consistency by providing up-to-date details such as locations, hours, contact information, and referral processes. The Ministry of Health

project team is reviewing and updating existing web content on opioid addiction treatment and addiction supports. Where appropriate the government websites will direct users to SHA resources to ensure people access the most accurate and current service information.

The SHA conducted a provincial review of the OAT clinic materials and created a standardized pamphlet for use across the province. This includes clear information on services, referrals, care teams, and contact details. Additional patient resources — handouts, posters, FAQs — have also been published internally for use across OAT; rapid access to addiction medicine, or RAAM; and virtual access to addiction medicine, or VAAM, services.

Surrounding the recommendation for the SHA to analyze provincial supply and demand for its opioid addiction treatment services, the SHA has completed a province-wide current-state mapping of opioid agonist therapy services in May 2024 through the provincial OAT project team.

[09:30]

The current-state mapping assessed client volumes, service distribution, prescriber availability, and program capacity and was used to inform initial site selection for the VAAM program. The analysis supported alignment of organizational priorities and informed early resource planning while also identifying underserved communities as opportunities for future phased expansion.

As part of the ongoing efforts to strengthen addiction services and better support clients, the implementation of VAAM is planned for communities that do not have access to a local clinic or an OAT prescriber in their community. VAAM currently provides service to over 20 communities and surrounding areas. SHA continues to work with the Ministry of Health through joint mental health and addictions planning processes to implement, to align funding with identified needs and service priorities.

With regards to the third recommendation, for the SHA to implement standardized approaches for its opioid addiction treatment services, the SHA has identified barriers to accessing opioid addiction treatment through program reviews, client surveys, and staff feedback and has taken reasonable actions within its control to address those barriers. Efforts include locating services near shelters and transit, partnering with community organizations, and expanding virtual care. The VAAM program is being developed to improve access for remote and underserved populations.

Services are currently delivered across multiple units and IT systems, limiting consistency and data comparability. The SHA is exploring the integration of existing OAT clinics into a provincial IT system and working towards standardized service delivery models.

The provincial OAT project team is working with SHA clinical standards to assess existing practices and develop provincial work standards aligned with the College of Physicians and Surgeons of Saskatchewan guidelines. The guidelines will include intake, assessments, treatment planning, referrals, and documentation.

SHA plans to support implementation of provincial standards through structured training, orientation materials, and ongoing education, including foundational training developed for the virtual access to addictions medicine program. SHA is working with eHealth and the Ministry of Health to explore options for improved data standardization and future system integration.

Regarding the recommendation for the SHA to consistently assess opioid withdrawal symptoms before prescribing OAT medication, the SHA out-patient opioid addiction treatment services follow multidisciplinary care models and are guided by provincial and professional standards, including the College of Physicians and Surgeons of Saskatchewan opioid agonist therapy standards and guidelines.

The SHA has initiated a provincial scan and survey to understand current use of opioid withdrawal assessment tools. The opioid agonist therapy prescriber advisory committee, or OATPAC, has been consulted in the review of best practices. The recommendations have been taken into consideration in determining how to best implement and provide recommendations on the most appropriate standardized opioid withdrawal assessment tools and clinical application.

The SHA is incorporating opioid withdrawal assessment training into provincial OAT training and orientation materials being developed by the provincial OAT project team. The SHA will strengthen monitoring processes, including periodic review of client files, to support consistent completion and documentation of opioid withdrawal assessments prior to prescribing. The SHA will develop processes to address situations where assessments are missed, including follow-up and corrective actions to reduce clinical risk.

With regards to recommendation no. 5, which is for the SHA to provide timely out-patient opioid addiction treatment services, the SHA has established and communicated to operational teams a provincial maximum wait time target of three days for initial access to prescriber following assessment for opioid use disorder. The SHA has allocated seven full-time equivalent clinical support positions to address high client volumes, staffing pressures, with an additional 3.5 FTEs [full-time equivalent] being allocated to further support service capacity.

The SHA is working with the Ministry of Health to optimize prescriber availability in high-demand communities, including Saskatoon and Regina, and the VAAM program to expand prescriber access and reduce wait times, particularly for underserved and remote communities.

The SHA has identified key performance indicators for opioid addiction treatment services, including wait times for initial and follow-up care, to be piloted in a clinical setting this year and expanded province-wide in the 2027-28 fiscal year. Monitoring and reporting processes are being strengthened with regular reporting to senior management to support accountability and timely corrective action.

Concerning the recommendation for the SHA to consistently complete discharge/transfer plans for clients receiving in-patient opioid addiction treatment services, we believe this is fully implemented now. The SHA in-patient addictions treatment services follow Saskatchewan alcohol and drug services program

guidelines, with an identified need to improve consistency in discharge and transfer planning.

The SHA has developed and implemented a provincial work standard for discharge and transfer planning for recovery treatment centres and in-patient programs aligned with the Saskatchewan alcohol and drug services program requirements. The work standard includes expectations for evaluation of client progress, aftercare planning, and coordination with community-based care managers prior to discharge.

The SHA has implemented a provincial file audit work standard to support consistent completion and documentation of discharge and transfer plans. Updated staff orientation and training checklists have been implemented to ensure staff consistently apply discharge and transfer planning requirements.

Related to recommendation no. 7, which is for the SHA to offer OAT medications to clients with opioid use disorder, the SHA is revising detox service protocols to ensure opioid agonist therapy is routinely offered to eligible clients with opioid use disorder as part of in-patient social detox care. Integration of opioid agonist therapy into detox and recovery treatment settings is being supported through the provincial opioid agonist therapy priority project.

The SHA has provided information resources to recovery treatment centres and detox centres to ensure clear understanding of pathways and how to access VAAM for clients in their care. The SHA is strengthening staff education with in-services to support consistent understanding of the role of opioid agonist therapy, client engagement, and appropriate clinical application.

With regards to the final recommendation, which is for the SHA to consistently track, analyze, and report key performance information, the SHA is establishing key performance indicators, or KPIs, to measure service effectiveness. This will include client volumes, wait times, retention rates, and client satisfaction.

The provincial OAT project team has started identifying metrics and developing standardized methods for collection and analysis. Data collection processes are being standardized across all out-patient and in-patient opioid addiction treatment facilities to ensure consistent tracking of client numbers, wait times, service utilization, and outcomes. This will allow leaders to monitor trends, identify gaps, and assess whether services are meeting demands.

Wait time reporting is being enhanced to improve accuracy and reliability. Reports will use calendar days, include both new and returning clients, and adhere to evidence-based reporting standards, including Canadian Institute for Health Information definitions. A province-wide review of current wait time reporting practices has now been completed and is being analyzed to identify gaps and inconsistency.

Client engagement and service quality measurement will be strengthened throughout development of regular client satisfaction surveys. These surveys will assess client experiences, quality of care, and recovery progress. Feasibility for public reporting of selected KPIs is also being considered to increase transparency and accountability. VAAM has integrated key performance indicators and is collaborating with digital health and brick-and-mortar clinics to extract and integrate electronic medical records data for consistent reporting across the province.

And that concludes my comments.

Chair Wotherspoon: — Thank you very much for the report. Thanks as well for the many actions that have been taken by officials with respect to these recommendations. But I'll open it up at this point to committee members that may have questions. MLA Pratchler.

Joan Pratchler: — Thank you, Chair, and welcome. When I look at recommendation 1, I was wondering, what other avenues does SHA use to provide clear and easily accessible information to the public who are suffering from addictions, don't have access to a computer system, or would have a reading level — or be it a physical situation — where reading in that kind of tool may not be the best for transmitting that information? Basically do you have workers on the front line that can help them do some kind of sorting and make some informed decisions as best they can to access prevention or treatment strategies?

Julia Pemberton: — Hi. Good morning. Thank you so much for the invitation to be here today. I'm excited to be able to comment on the work we're doing to support the auditor's report. My name is Julia Pemberton, and I'm the vice-president for integrated north, and the executive sponsor for mental health and addictions for the province.

Great question, MLA. Thank you very much for it. And there's a few different ways of navigation that the Saskatchewan Health Authority supports connecting people to care beyond the pamphlets, the websites.

So we have three different places where people can interact with care. We have our wellness buses, which are out in community meeting people where they are at, which has an addictions counsellor, a nurse, and a nurse practitioner often on board who can support connection to care. We also have our outreach teams in several of our urban communities that meet people on the street or where they're at in shelters. And then within our ER [emergency room] system we also have mental health workers and ER nurses who are able to connect to addictions services for care.

Joan Pratchler: — Would that be the same in our urban centres?

Julia Pemberton: — Yes.

Joan Pratchler: — Okay. I'm noticing on here the timeline for implementation is next year. What's not implemented yet that takes another year to get implemented?

Julia Pemberton: — For recommendation no. 1?

Joan Pratchler: — Yes.

Julia Pemberton: — Thank you for the question. One of the things that we have done with our website, right, is introduce our new search-by-service function in May of this year. And so we're building upon that to expand our website to have interactive capabilities as well as youth-focused content. So that will be

achieved this year; as well as we're working on the expansion of VAAM.

So we've started in 20 communities, but we're working towards a provincial expansion. And with that expansion there'll be a series of education materials that will go to those communities once VAAM is available to them.

[09:45]

Joan Pratchler: — Thank you. A standardized OAT program was going to happen by 2028. Would you be able to describe some of the milestones that need to be achieved as part of that standardization? And what's the timeline for those milestones as well?

Julia Pemberton: — Hi. Thank you. So there are a few different parts of our phased expansion between this year and next. So this year we plan to develop and implement provincial work standards that align with the College of Physicians and Surgeons of Saskatchewan guidance. As well we're going to start, and continue into 2028, advancing the establishment of our community of practice to support consistent application of standards and shared learning across the province.

The IT program, as you can imagine, is a little bit more complex. So it's going to continue into 2028, and we will advance standardized data and IT processes to improve consistency, reporting, and decision making. And then by 2028 we will implement that provincial oversight mechanism to support consistent service delivery and resource alignment.

Joan Pratchler: — I'm looking at recommendation no. 2. It appeared in the auditor's report in 2025, which means that the situation was occurring well before that. And now it's 2026 and it's not ready to get rolling till 2027. We have an opioid crisis and have had it for a very long time.

I'm also wondering too, just with those dates in mind and looking at the future, what are your key successful tenets, you know, for prevention of opioid and drug toxicity and the programming that could prevent having to have such a massive recovery model?

Julia Pemberton: — Thank you again for the question. So the SHA does acknowledge that historical data limitations, including decentralized service delivery models and multiple information systems, have constrained the ability to conduct comprehensive provincial-level analysis.

And to strengthen data-driven planning, the SHA is planning additional analysis to better understand factors influencing wait times, including client demand, prescriber availability, clinical hours, and service models across communities. A survey and environmental scan are being planned to identify contributors to wait time variation between high-demand communities, including Saskatoon and Regina. And we have invested seven full-time equivalent staff in brick-and-mortar clinics to better understand opioid agonist therapy resources, and there's another 3.5 FTE initiated this year.

Joan Pratchler: — And so could you just identify what your tenets of your prevention programming is? Is that it?

Julia Pemberton: — Thanks. One of the key tenets for prevention is appropriate opioid stewardship. So we're working with the College of Physicians and Surgeons on appropriate management of opioid prescription.

Joan Pratchler: — And that leads to my next question. So would you be able to identify the key — I'll call it tenets; I'll think of a synonym in about five minutes — that have been suggested by the College of Physicians and Surgeons in addressing opioid addictions treatment but also prevention?

Julia Pemberton: — Thank you for the question. And so we work to align our opioid stewardship program with the College of Physicians and Surgeons. So I would just point you to our opioid stewardship program website that outlines the key tenets of that program.

Joan Pratchler: — Yes, and it's been clear that there has been some maybe not close alignment with what some of the standard practices are. Anyway, so just flagging that.

So I've been on Public Accounts Committee for the last year and a half, and it seems consistently that whenever SHA comes up, that there's always challenges with the IT system. And it seems to be a real need to be able to have accurate data to be able to pivot on some things that really have to be pivoted on quickly. There are some systemic things, granted. But there are some things, especially with people dying left and right in opioid addiction, that perhaps if we had data snappy like that, we might be able to address it better, and we wouldn't have to see these sad stories on the news.

And I don't know if you could help me understand what you're doing to encourage eHealth or any other IT department to, you know, crank up the speed on some of these kind of programming and some of these kind of internal things that must be the root causes for not getting an IT system. And I don't want to go through the list because that wouldn't be kind, but it's been documented and flagged for years. And we know in health care, we know in education, we know that unless we have that data in a timely manner, it usually is a waste of money, waste of time, and a sad, sad story about people hurting and dying.

So summary, what are you doing to encourage your IT departments, or the ones that you outsource to, to pick up the pace and meet the needs as timely as we need and demand and have to have in this province for the people of Saskatchewan?

Julia Pemberton: — Thank you. So local IT systems were developed, as you know, over time in the former health regions, and they're often integrated with local primary and acute care resources which do allow for care coordination across the service continuum locally. And through the guidance of the provincial mental health and addiction services leadership, the SHA is exploring how to better integrate existing OAT clinics to utilize the provincial mental health and addictions information system, or MHAIS, while maintaining core functionality provided with local EMRs, or electronic medical records.

[10:00]

So one of the things we have done is develop the MHAIS system, which is a dedicated IT system to mental health and addictions.

And that system is available to all SHA acute care facilities and in-patient facilities in mental health and addictions. And we're working to roll that system out with our recovery treatment centre partners and will be completed by 2028.

Joan Pratchler: — Have parameters been set in for the rigour of evaluating it?

Julia Pemberton: — The evaluation will be part of the built-in key performance indicators for the MHAIS system.

Joan Pratchler: — So are those ongoing, or are they going to be at the end of 2028 in March?

Julia Pemberton: — Ongoing.

Joan Pratchler: — Ongoing. Okay, thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Thank you. There's a lot of discussion of virtual care to address existing barriers, but the auditor rightly pointed out that virtual care developed new barriers. So I'm just wondering if there's any plan to expand mobile or home services? I guess Medavie has developed a few home detox programs to their community paramedicine programs such as in Moose Jaw and Saskatoon. But they're very limited.

Julia Pemberton: — Thanks, MLA, for the question. And yes, you are correct. We have started with those two communities, but ongoing discussions to expand that service are currently under way.

Hugh Gordon: — Do you have a timeline for when you expect that rollout of that expansion? Like a plan for that expansion, and what your plans look like at this point?

Julia Pemberton: — It's part of the 500-spaces initiative that will be completed by 2028.

Hugh Gordon: — Okay. How in your view has the closure of Prairie Harm, though, changed this data? Can you tell us the wait times for Saskatoon since Prairie Harm closed, and can you provide that information today?

Julia Pemberton: — Thanks for your question. So with the closure of the Prairie Harm services, we have been really closely engaged with the community-based organizations, and we've made sure that there is no gaps in the continuity of care. We do report our wait times quarterly, so we don't have them here today.

Hugh Gordon: — Would you be able to provide that to the committee in a reasonable amount of time, reasonable time frame? How long would that take to provide the committee?

Julia Pemberton: — The end of quarter 2 is the end of June, and we'll be evaluating that data in July.

Hugh Gordon: — So 30 days' time? Would that be . . . Sixty days' time? Thank you very much. We'll ask for that then. Thank you. We'll have you table that.

Chair Wotherspoon: — And in the previous quarter, you're saying the previous quarter would have been reported out, you're saying then.

Julia Pemberton: — The closure of Prairie Harm Reduction was at the end of quarter 1, so we need a full quarter to understand if wait times have been impacted.

Hugh Gordon: — Thank you. What are you doing to inform the public of inaccessible services such as treatment facilities, no available beds, or closed sites such as Prairie Harm Reduction? And are you making that information available offline as well as online?

Julia Pemberton: — Thanks for the question. So as reported earlier, our search-by-service which was launched in May 2025 outlines all of the services that are available to the public. And in terms of the Prairie Harm Reduction, we don't directly fund that service. So we wouldn't comment on their services, but our teams that are connected locally are well aware.

Hugh Gordon: — Okay. I think this all comes back to, you know, how you communicate what service is available in an effective way to the public or people who are looking for addictions treatment, right? And I know MLA Pratchler had asked a question previously about what about individuals that have limited access to the internet — or perhaps have physical or mental limitations with respect to getting information online — and how you are going about trying to provide that information in more of a hard-copy format, correct? Like a nondigital transmission of that information to them.

And so I just was wondering if you could expand on how you manage to improve clarity of that information that you're communicating to them. And have you solicited any public feedback on whether or not people found that information, the nondigital information, more clearly communicated? Because really at the end of the day we want anyone that needs that help — however they go about looking for it — can get it, right?

Julia Pemberton: — So in response to your question, we do have several different modes of access for information. So we do support the idea that no door is the wrong door. And so as mentioned before, our search-by-service on the website, we did have patient family partners engaged in creating that service to make sure it does meet people's needs for clarity.

We also continue to have our outreach teams, our ER navigation teams, our wellness bus teams locally, who are very aware of the services that are available in their home communities and happy to meet people where they're at. And then across the province we have 811 which is just a phone call service that people can access that will have a very clear line of sight into what services are available and how to navigate people to those services.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Julia Pemberton: — Finally — sorry, just one point I forgot to add — and then finally this year, as stated previously, we are doing client satisfaction surveys across the OAT portfolio which will inform if we're meeting those needs on clarity and access

and readability.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — I'd like to talk a little bit about the OAT program, or O-A-T. What is the current average wait time for an OAT medication prescription and how many cases exceed, you know, that three-day maximum?

Julia Pemberton: — Provincially? Or are you looking at a specific area?

Joan Pratchler: — Well that would take forever if we did specific areas. But are they following the practices of doing it within three days? If not, why not?

[10:15]

Julia Pemberton: — Thank you. I was just checking my latest data. So we have data up until March 2026, and across Saskatoon, Prince Albert detox and Prince Albert urban, Kamsack, and Regina, our average is meeting the three-day expectation. We have implemented though VAAM, which is . . . The goal of VAAM, virtual access to addiction medicine, is same-day access. So we're even wanting to make sure we're exceeding that three-day expectation, and with one phone call you'll be directly connected and be able to have a same-day start for your OAT therapy with the VAAM. And that's the success we're seeing in those 20 communities.

Joan Pratchler: — So those are the main ones that you looked at. Do you have any consistent outliers? And if you do, how do you address that for, you know, maybe if they are outliers consistently?

Julia Pemberton: — So we do continue to monitor key performance indicators. As we stated previously, we've done a lot of work to enhance those KPIs this year, and wait times are one of them. So we continue to monitor that quarterly and make investments in the high-need sites that need it to reduce those wait times, including the seven FTE last year that was invested and another 3.5 FTE invested this year in brick-and-mortar clinics at the front line in those sites.

Joan Pratchler: — So when we look at . . . you know, urban would be obviously, you know, higher populated. What are sort of the metrics that we're using in rural, and do they have the same kind of three-day real-time hallmark standard, I guess, of that? So what I'm seeing here — and I guess my question's a little bit all over the map here — urban looks like managing quite well. There doesn't appear to be any outliers. But what about rural?

Julia Pemberton: — Great question. So with rural, that's actually where we're seeing the best benefit of the virtual access to addiction medicine program in those 20 communities. And how we identified those communities was through that provincial scan to identify communities that had high wait times, had no local access to the OAT program. And we were able to prioritize those communities for the virtual access to addiction medicine so that they have same-day access.

Joan Pratchler: — Gold star. Thank you. Let's talk discharge planning. So you know, treatment is one thing, but that it continues on and is part of that process of ongoing . . . People are recovering alcoholics for their entire life.

Let's talk about discharge planning and what kind of tenacity and continuity is helping clients be able to be successful after treatment/moving into recovery, which is for life. How frequently are patients receiving discharge plan? And secondly, how is that being monitored for follow-up for what we know is best practice, as recovery is lifetime?

Julia Pemberton: — So the SHA contracts and service agreements with our community-based organizations reinforce the expectation for wraparound and holistic supports, including coordination with community recovery teams, peer supports, and SHA mental health and addictions services. These actions are intended to strengthen transitions from in-patient treatment to community-based services, reduce the risk of relapse, and support sustained recovery as we've adopted a recovery-oriented system of care model for the province.

And as part of our 500-space initiative in partnership with the Ministry of Health, we do include post-treatment spaces in that new initiative. So we continue to add net new transitional spaces to the province to help people transition to maintain their recovery. And we have work standard audits in place now since the audit to make sure that we're in 100 per cent compliance with our discharge planning.

Joan Pratchler: — So do I hear you say 100 per cent of clients have a discharge plan?

Julia Pemberton: — And we have a work standard to audit that, to ensure.

Joan Pratchler: — And what would be the criteria involved in that in terms of connections to community supports afterwards, in terms of how many clients might relapse and have to re-access services? What would be the criteria in that evaluation of discharge planning indicators?

Julia Pemberton: — So in the discharge planning document it does make sure that we connect to multiple points of care. Each client's discharge plan will be different and adaptable to their needs, but each plan does make sure we connect to those supports.

Joan Pratchler: — Thank you. How many different programs are currently being used across clinics? And does VAAM track the different programs? Or how does that work? Does there need to be consistency? Is there consistency? And how is that evaluated? Because my guess is that, you know, a whole bunch of different programs, you know, across the board, they'd be different from clinic to clinic.

Julia Pemberton: — What kind of programs are you referring to?

Joan Pratchler: — The programs that they would go out to access in the community as follow-up after their discharge plan. So they have a discharge plan; they're asked to go check in with person X or program X. Is that followed up as well once they go through? And maybe it is, and maybe you've already answered that.

Julia Pemberton: — So part of the discharge planning process is to make sure that we are referring and connecting clients to care. The number of services that each client needs is going to vary based on the individual client, so we make sure that we provide that warm hand-off over to those services.

We also are, as I said earlier, engaging in an evaluation. And so whether those services are followed up on and how many people are connecting to those services is something we can consider for that evaluation.

Joan Pratchler: — Which brings me to the next question. Being able to measure treatment outcomes is really important. How is SHA assured that these programs are effective and that there is a measuring tool that's going to do that? Or is there a measuring tool that measures the effectiveness of the treatment?

[10:30]

Julia Pemberton: — So I'll start with what information the SHA uses at the senior management level to evaluate performance of our opioid services across the province. So we currently review quarterly VAAM key performance indicator reporting, which includes number of visits, number of unique clients, location, wait times, same-day starts, referrals, transitions to community, and other key indicators. The SHA is developing standardized definitions and data collection methods, especially for wait times, to scale a consistent KPI approach across all OAT clinics provincially.

We're also developing a client experience and outcome survey to implement provincially this year alongside the above-mentioned KPIs to determine the effectiveness of OAT programming in the province. This is going to work alongside the full expansion of our mental health and addiction information system, which will provide that fuller provincial picture when that's fully implemented by the end of 2028.

Joan Pratchler: — Okay. Can you tell me the percentage of clients that remain in treatment after 30 days, 90 days, and a year?

Julia Pemberton: — So thank you for the question. We don't currently track that right now. And we recognize that OAT therapy is individual, and individuals can have a different length of treatment, and some of those treatments can last more than one year.

Joan Pratchler: — Absolutely. So my next question was going to be about the cost per successful treatment, but I mean we can't see into the future. This program that you've initiated, it began when? I forget.

Julia Pemberton: — VAAM?

Joan Pratchler: — Yeah.

Julia Pemberton: — December 2024.

Joan Pratchler: — Okay, so it's quite new.

Julia Pemberton: — Very.

Joan Pratchler: — So right now would you have a ballpark of the cost? Even if you projected it for a year. Like you'd know it up to now. What would be the cost for the VAAM program yearly or what you know now?

Julia Pemberton: — So the budget for the VAAM program for this fiscal year is 3.6 million. We would need a full year of implementation to understand on a per-patient cost.

Joan Pratchler: — And VAAM is only one part of the programming or the supports that are provided. That's just the virtual part. What would be the budgetary impact of the whole treatment — so that is more than just the virtual; that's the supports — per client? How would we be able to access that amount of what it costs per person to enter the system, get supports as best they can?

And I know it could be years before someone truly goes through. But what would be the yearly cost of somebody going through a program? If they receive treatment and they're fine and they've really had a successful recovery within that year, how much is it costing to do that? Does that make sense?

Julia Pemberton: — So as you can appreciate, that's probably a very difficult question to answer because every treatment journey for a client is highly variable. So it's not something we could answer at this time.

Joan Pratchler: — Well and that's it, and I don't know if you're planning on looking at it. Because we know the exact costs it would be of a hip replacement, knee replacement. And are there going to be outliers? Yeah. And there's probably a standard that we can land on — somebody landed on — for hip replacements, for knees, for a variety of surgery. Is that something that we're looking at, to get some kind of costing on what it is per treatment to go through these facilities?

And how much must we budget for? When we know person X is beginning treatment, the basic level of care is going to cost this much. If they go beyond six months, it's going to cost this much. So what processes are you putting in place? I mean this is a new kind of . . . It shouldn't be a new kind of medicine. It is. But how can we quantify that to do proper budgeting and then of course evaluation on value for funding for that?

Julia Pemberton: — So I appreciate the question. And as I said before, a patient journey is highly unique. It is more unique than a hip surgery, and we're still in the early stages of developing the VAAM program.

I will also say that with the mental health action plan that is being implemented between now and 2028, the system has a variety of changes that are coming to provide different supports. So once the system stabilizes, I think we could take that under advisement.

Joan Pratchler: — Thank you. And that's the last question I have. Thank you.

Chair Wotherspoon: — Listen, good exchange there, folks. Looking to see if there's any other questions. I see MLA Keisig.

Travis Keisig: — Thank you, Mr. Chair. I just really wanted to compliment the auditor and the SHA team for the very limited

use of acronyms. It's very important that we use the entire words. There's Saskatchewan people watching these deliberations. And just a thank you to the team for doing really good work. Thank you, Mr. Chair.

Chair Wotherspoon: — It's a reasonable point, hey, because sometimes the acronyms are so common in the respective disciplines or ministries or work. But you're right, to the average public who cares deeply about these matters, a lot of the acronyms can sometimes, you know, cloud that conversation. So a reasonable point there, Keisig, and thanks for making it.

Not seeing any further questions, again thanks to all those that have been engaged in this substantive work for the actions that have been taken and for the actions that have been committed to seeing these through to implementation.

I'd welcome a motion at this point to concur and note progress with recommendations 1, 2, 3, 4, 5, 7, and 8. And yeah, I'll take that one and note progress. And Deputy Chair Thorsteinson moves. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — Okay, that's carried. And I'd welcome a motion to concur and note compliance with respect to recommendation no. 6. Moved by Deputy Chair Thorsteinson as well. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried also. I'll turn it back over to the Provincial Auditor. Of course that last chapter was a brand new chapter, first time it was considered before us. So you know, a fairly substantive set of questions and consideration at the table. These other ones have been considered at this table before, so they're follow-up audits, follow-up consideration. I'll turn it over to the Provincial Auditor for the 2025 report volume 1 and to focus on chapter 12.

Jason Wandy: — Thank you, Mr. Chair. The Saskatchewan Health Authority is responsible for constructing, renovating, altering, maintaining, and managing its health care facilities. There are over 50 health care facilities located in Saskatoon and surrounding areas, serving over 360,000 Saskatchewan residents in more than 100 communities.

Chapter 12 of our 2025 report volume 1 reports the results of our second follow-up audit of management's actions on the eight remaining recommendations we originally made in 2019 regarding the Authority's processes to maintain health care facilities located in Saskatoon and surrounding areas. By November 2024 the Authority implemented four recommendations and continued to work on addressing the remaining four recommendations.

First I'll touch on the improvements the Authority made. The Authority implemented a maintenance IT system in 2023 to help control the accuracy of maintenance data and develop standardized preventative maintenance activities for key health care facilities and components.

[10:45]

It also worked with the Ministry of SaskBuilds and Procurement to assess its facility conditions and established a formal service objective to help determine potential facilities or components at risk and those in immediate need of maintenance. In 2024, 50 out of the 66 facilities in Saskatoon and surrounding area were assessed as good or fair condition, meaning 16 facilities were in poor condition.

The Authority also revised its capital planning strategy to confirm capital project funding aligns with established priorities, and our testing found appropriate rationale for capital project prioritization and funding requests.

Now I will cover the four recommendations that remain outstanding. The Authority partially implemented the recommendation on page 147, where we recommended the Saskatchewan Health Authority complete preventative maintenance on its key health care facilities and components located in the city of Saskatoon and surrounding areas within expected time frames.

In April 2023 the Authority established a work standard setting out expected time frames for completing maintenance of facilities and component assets, based on a combination of a priority rating and maintenance frequency. However, when testing maintenance work orders in November 2024, we found certain staff were not aware that the work standard existed and therefore were not following the expectations outlined in the work standard.

Our testing of 30 preventative maintenance work orders found staff completed only eight work orders within the expected time frames; that is, 73 per cent not completed timely. Lateness ranged from 4 to 96 days late. Our testing also found the maintenance IT system allows staff to generate multiple work orders for the same maintenance procedure, creating the risk of staff duplicating work.

Not completing preventative maintenance in a timely manner increases the risk that an asset may fail and cause harm to residents, patients, visitors, or staff. This could also lead to increased future repair costs.

The Authority partially implemented the two recommendations on page 149, where we recommended that the Saskatchewan Health Authority have written guidance for classifying and prioritizing requests for demand maintenance on key health care facilities and components located in the city of Saskatoon and surrounding areas, and the Authority complete demand maintenance in line with priority rankings for key health care facilities and components located in the city of Saskatoon and surrounding areas.

In October 2023 the Authority developed a work standard to prioritize demand maintenance requests in the maintenance IT system by assigning an associated risk and desired time frame to complete each request. The system automatically assigns all orders as major risk, and thus all requests are given emergency priority. Previously no expectations to adjust this rating existed.

Starting in August 2024, Authority staff started to adjust priority ratings for maintenance requests to align with the work standard. Our testing of 30 untimely demand maintenance requests

completed found 10, or 33 per cent, have priority ratings set per the established work standard. Most requests continue to be ranked at the highest emergency priority level, which can lead to prioritizing completion of less critical requests before other more significant requests.

We also analyzed over 6,300 demand maintenance work orders closed between August and October 2024 and found staff completed 85 per cent of work orders within the expected response time frames. Most work orders not completed timely were classified as major risk. When demand maintenance requests are not appropriately prioritized, there is increased risk personnel do not first complete priority maintenance of assets critical for the delivery of health care services. Not completing timely demand maintenance in order of actual priority increases the risk that key assets may remain unrepaired longer than expected.

The Authority partially implemented our recommendation on page 151, where we recommended the Saskatchewan Health Authority use its planned maintenance activities as an input to setting its Saskatoon-area maintenance budget. We found the Authority continues to establish its maintenance budgets based on historical figures. We found the maintenance IT system includes several capabilities to assist the Authority in understanding costs associated with planned maintenance activities. For example, the system can capture data on age, life expectancy, useful life, warranty and replacement value costs for all equipment. Not using planned maintenance activities to set budgets increase the risk of insufficiently funding all required maintenance. This can lead to the Authority not completing maintenance at appropriate times and deferring maintenance.

I will now pause for the committee's consideration.

Chair Wotherspoon: — Okay, thanks so much for the focuses, presentation, the follow-up work on this front. As a note, these have all been considered of course before us in the past year, full agreement by the committee on each recommendation. Thanks for detailing the actions on the status update where implementation has occurred or what actions are required still to ensure implementation in those timelines. Any comments or quick words before we open up for questions?

Norman O'Neill: — Yeah, I'll just preface my comments on recommendations 4 through 7 as the others are considered implemented. So starting at recommendation 4, which is for the SHA to complete preventative maintenance on its key health care facilities and components. The SHA has developed a building operations maintenance program in supporting work standards. These standards will help guide preventative maintenance activities, including defined procedures and expected timelines.

The SHA implemented a computerized maintenance management system to support scheduling, tracking, and reporting of preventative maintenance activities, including standardized frequencies and timelines for maintenance tasks. The SHA continues to advance the completion and refinement of remaining maintenance programs and work standards to further strengthen consistency and support full alignment with expected preventative maintenance time frames. A tracking and escalation process is in place within the computerized maintenance management system to monitor maintenance performance and support timely completion of preventative maintenance activities.

Regarding the recommendation for the SHA to have written guidance for classifying and prioritizing requests for demand maintenance on key health care facilities, this is considered fully implemented by the SHA. The SHA has established a demand maintenance prioritization work standard within the computerized maintenance management system, providing guidance on assigning risk ratings, expected response, and completion time frames for maintenance requests.

A centralized intake process has been implemented where demand maintenance requests for Saskatoon-area facilities are routed through a call centre and assigned priority ratings using standardized approaches. The prioritization process defines risk levels and associated service expectations. Further refinement of guidance and controls is ongoing to support consistent application of priority ratings across all users and scenarios.

With regards to the recommendation for the SHA to complete demand maintenance in line with priority rankings for key health care facilities, the SHA implemented monitoring and reporting processes within the computerized maintenance management system. This will track demand maintenance performance against established priority levels and service expectations. Demand maintenance work orders for Saskatoon-area facilities are centrally routed and prioritized, supporting alignment between assigned priority levels and expected response and completion time frames.

Key performance indicator reporting is in the testing phase to ensure appropriateness and quality of data. Our reporting and escalation framework is being developed to support follow-up on delays and variances from expected timelines with ongoing refinement to strengthen consistent use and effectiveness of escalation practices. This is in the design phase, with a team testing current options.

Management continues to work with operational staff to implement alignment between assigned priority levels and actual completion timelines supporting more consistent execution of demand maintenance activities based on risk.

For the final recommendation I'll touch on, which is for the SHA to use its planned maintenance activities as an input, the SHA developed a risk-based maintenance planning approach for key health care facilities and components in Saskatoon and surrounding areas. This is to support prioritization of maintenance needs and inform annual budget discussions.

The SHA continues to work with the Ministry of Health to strengthen capital and maintenance planning processes, including aligning maintenance priorities with funding requests. The computerized maintenance management system has been implemented to capture detailed data on assets, including condition, life cycle, and maintenance requirements, which support more informed budgeting. While the computerized maintenance management system has the capability to support forecasting of planned maintenance activities and associated cost, its use as a primary input into the maintenance budgeting process is still being advanced.

The SHA is progressing data validation, standardization of equipment information, and development of reporting capabilities within the computerized maintenance management system to support future integration of planned maintenance activities into the budgeting processes.

And with that, I'll conclude my comments.

Chair Wotherspoon: — Thanks for the comments. Thanks for the actions that are reflected there. And I'll open up to committee members that may have questions. MLA Pratchler.

Joan Pratchler: — Thank you. And thank you for that summary. Can you tell me when was the most recent FCI [facility condition index] assessment completed for all the facilities in the province?

Derek Miller: — Good morning. I'm Derek Miller. I'm the chief operating officer with the SHA, and happy to be here today to support response to questions.

So the last facility condition index inspection occurred in 2025, and we're now on a rotation where every year a quarter or one of the geographical areas in the province between North, rural, Regina, and Saskatoon will be inspected, so that every four years we would expect a facility to have an updated FCI assessment.

And I'll also add that as we perform maintenance activities — replace a roof, a boiler — we provide that to SaskBuilds and Procurement into the system so that that is accounted for in terms of the FCI rating. And I just want to note that the tool, the FCI assessment, is operated by SaskBuilds and Procurement, and it supports consistency in terms of health facilities with other assets that are owned by the government.

Joan Pratchler: — So SaskBuilds would provide you that report, and that's how you would determine, you know, the needs and responses to those assessments. Is that correct?

Derek Miller: — Yeah, we have access to the system that SaskBuilds and Procurement uses, so we're able to look at a facility basis to understand what the assessment is telling us. And then we use that information in order to inform our budget planning process for identification of projects for the budget cycle.

Joan Pratchler: — Okay, thank you. That sounds awfully . . . compared to what happens in education, that you have the facility condition index and then it's usually, you know, rated in, you know, good, fair, excellent, that kind of thing. Could you furnish that report of the facility index and how many are in the different categories to the committee for all the facilities in the province to date.

[11:00]

Derek Miller: — Okay. The way the facility condition index assesses and assigns a condition is in four categories: good, fair, poor, and very poor.

I'll say that from the 2025 FCI condition reports, our average was in the "good" category. And I'll just go through the number of facilities. So there's 311 total facilities, and that includes facilities where clinical services are provided as well as other facilities that may be support, like a parkade, for example.

So in the "good" category there were 126 facilities, which is 40.5 per cent. In the "fair" category, 71 facilities or 22.8 per cent. In the "poor" category, 109 facilities or 35 per cent. And in the "very poor" category, five facilities or 1.6 per cent.

Joan Pratchler: — Would you be able to provide the committee with the itemized list of the facilities and their ratings?

Norman O'Neill: — I'll answer it. So we can't. We'll have to follow up with SaskBuilds and Procurement to get the itemized list, but we could do that within the next 30 days if that works.

Joan Pratchler: — That would be perfect. Is that the discussion with SaskBuilds, or that will be the time I get the paper in my hand?

Norman O'Neill: — We'll have it to the committee, or however tabling typically works, within 30 days.

Joan Pratchler: — Okay.

Chair Wotherspoon: — Yeah, thanks so much. And just to confirm through the Chair here that we really appreciate that undertaking to get that information to us within 30 days is excellent, and that can be supplied through the Clerk. And they'll extend to you what that process looks like, although I think you're familiar. So thank you very much.

Joan Pratchler: — Might I ask just specifically about Saskatoon's facilities. What was the average FCI for Saskatoon and the area . . . What was their level of condition for that . . . I'll say Saskatoon region; let's just call it that.

Derek Miller: — I don't have the breakdown for Saskatoon, but it would be included in the report that . . . [inaudible].

Joan Pratchler: — Maybe it would be in that list that we . . .

Derek Miller: — Yeah.

Joan Pratchler: — Okay, yeah. So what would be done for a cost-benefit analysis for preventative maintenance versus repairs? And are you able to identify what preventative maintenance saves in a dollar amount?

Derek Miller: — I want to just acknowledge the importance of preventative maintenance for any kind of asset buildings, very important for making sure we get full value out of the life cycle of an asset. Also want to acknowledge, especially in our environment with delivery of health services, that the operation and function of our buildings and the equipment in them is very important for the ongoing provision of clinical services to the public.

I would acknowledge that break-fix happens like through the course of the year, and we're responsive to that. But we do focus on preventative maintenance. In terms of your specific question around the cost of a preventive maintenance program versus repairs, we don't have that type of information to be able to share.

Joan Pratchler: — Okay. So with this new

CMMS [computerized maintenance management system] system, what kind of reports is it able to produce?

Derek Miller: — The computerized maintenance management system is a key enabler for us in terms of how we manage our maintenance program within the Saskatchewan Health Authority. It is our repository for all of our assets, and it's where we capture service requests that may come in from users out within our facilities, or of things that might be broken.

It's also where we manage our preventative maintenance program and identify what needs to be checked or monitored or whatever the task might be required for specific preventative maintenance. So a very important tool for us and it allows us to provide oversight of how we are performing.

And the Provincial Auditor noted, for example, our responsiveness to demand maintenance. We prioritize those based on risk, and then are we actually addressing the requests within those timelines. So we're able to, from a management perspective, provide oversight in terms of are we meeting the required timelines for that as well as for preventative maintenance.

It allows us to plan our maintenance based on what's coming up. We're able to look ahead this month, this week, what is coming up for preventative maintenance, and then assign resources to be able to do that within our teams, but then also from an oversight perspective, monitor how was our . . . is our team meeting the maintenance needs within a given facility.

So there's a number of different types of reports that managers would be using in order to manage the business, but also reports that are available to our leadership in order to provide oversight, and how are we achieving the targets in terms of responsiveness to our maintenance demands or preventative maintenance.

Joan Pratchler: — So it appears that there is a summary report provided to leadership. Is that quarterly or yearly generated?

Derek Miller: — Depending on the level of leadership, certainly the director of the maintenance program within each area, or within Saskatoon in this case, would be getting regular updates and have access to the information from CMMS to manage the program. Some of the reports would be shared on a frequent basis through the management structure.

Joan Pratchler: — And so they would eventually be furnished to the board.

Derek Miller: — We're not currently reporting . . . We have a number of key performance indicators that we provide to our board. The maintenance responsiveness, the type that would come out of the computerized maintenance management system, we're not currently reporting on any of those to the board. But then certainly within the leadership team there is visibility on and oversight of the maintenance program.

Joan Pratchler: — So are they reported publicly in any way?

Derek Miller: — We're not currently reporting publicly on the measures out of the computerized maintenance management system.

Joan Pratchler: — And is that an intention that that will be happening?

Derek Miller: — As I mentioned, currently we're not pulling information from the computerized maintenance management system to report publicly. And we see this system as an operational management system for us to be able to manage and deliver our program. I will point out though that we do provide information on our capital program, capital expenditures, and projects as part of our annual report that the Saskatchewan Health Authority provides.

Joan Pratchler: — And in that capital report, is there . . . And I haven't seen that. Is there mention of key maintenance projects that need to happen because they're an emergent nature of any type? Or is it just new builds?

[11:15]

Derek Miller: — The Saskatchewan Health Authority annual report, as I mentioned, includes our capital plan, and it does identify our capital maintenance program expenditures for the year within that. It's where we would capture roof replacements, boiler systems, nurse call systems — all the various building types of projects. But we don't provide a granular list of those; there's over 300 facilities within the SHA. But it would pull from all of those projects across the province into that update on capital expenditures.

Joan Pratchler: — So where would someone in rural Saskatchewan be able to find out if their hospital or their health care facility needs repair, on the list, and is expected to get some, you know, mitigation for whatever concern they have? I guess that's why I'm asking, where is it publicly available so that people know where their facilities rate and what they need to do to help support their facilities being maintained?

Derek Miller: — Thanks for the question. There's a few different avenues that a member of the public could engage in conversation or learn more about maintenance that might be happening within our facilities. One is we have site leaders identified across all of our sites. And site leaders are aware and participate in planning for their facilities and is a point of contact for the public to be able to ask questions and learn more about what's happening within their local health facility.

Also we have a number of health foundations across the province that support different facilities. That's another means for the public to engage in and learn about what are the needs of a specific health facility, what projects might be on the horizon, and how they could potentially be interested in supporting that.

Joan Pratchler: — So if I understand correctly, internally you have the CMMS. Externally would be these last few that you just mentioned for wanting to find out what the, you know, facility condition is. Is that correct?

Derek Miller: — Correct.

Joan Pratchler: — Okay. Are there any high or urgent priority projects related to hygiene or sanitation in Saskatoon facilities or their parking lots? Heat, air conditioning, elevators in the Saskatoon facilities that are, you know, emergent or urgently

needing help?

Norman O'Neill: — So I think we're going to try and use the phone-a-friend option, and if it's okay with you we'll . . . We do have various breakdowns of categories like you've mentioned. So I just want to confirm, the four that you had noted were HVAC [heating, ventilating, and air conditioning], parking lot, sanitation, and hygiene?

Joan Pratchler: — Yes. Did you say elevators?

Norman O'Neill: — No.

Joan Pratchler: — Okay. There you go.

Norman O'Neill: — But we'll confirm that that's the other one.

Joan Pratchler: — So hygiene, sanitation, parking lots, HVAC, and elevators.

Norman O'Neill: — So we don't have that right at this moment. We'll try and get it so that we can read it into the record after lunch if that works.

Joan Pratchler: — Sounds good to me. Thank you. That's all the questions I have. Maybe Hugh has a few more.

Chair Wotherspoon: — Any other questions on this chapter from committee members? Not seeing any, I'd welcome a motion to conclude consideration of chapter 12. Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We're going to move right along and turn it back over to the Provincial Auditor to focus on chapter 13.

Jason Wandy: — Thank you, Mr. Chair. The Saskatchewan Health Authority purchases goods and services to support the delivery of health services each year. The Authority directly purchased approximately $123 million in goods and services between July 2024 and January 2025.

Chapter 13 of our 2025 report volume 1 reports the results of our first follow-up audit of management's actions on eight recommendations we originally made in 2022 regarding the Authority's processes to purchase goods and services over $5,000. By February 2025 the Authority implemented seven of the eight recommendations.

The Authority appropriately documented rationale when making single and sole-source purchases, including when using credit cards to purchase goods and services, to show best value sought when making purchases. It authorized the initiation of purchases and written contracts for goods and services in accordance with its delegation of signing authority.

It consistently evaluated potential suppliers and obtained conflict-of-interest declarations from tender subcommittee members when tendering for goods and services to help demonstrate fair treatment of suppliers. It also communicated with suppliers about award decisions for public tenders, which helps convey fairness and transparency in the Authority's purchasing process.

The Authority did not implement the recommendation on page 161 where we recommended the Saskatchewan Health Authority establish a formal process to assess and track supplier performance.

The Authority does not formally assess whether suppliers performed to a satisfactory level, such as timelines met or acceptable quality of work after the conclusion of a contract or after its receipt of goods and services. Management indicated the Authority was developing a formal process to assess and track supplier performance which it expected by March 2026. Without a consistent process to assess and track supplier performance, there's increased risk of the Authority using unqualified or inappropriate suppliers in the future.

I will now pause for the committee's consideration.

Chair Wotherspoon: — Okay, thanks so much for the important follow-up on this front. Thanks to Health for providing the update with the implementation that's been highlighted. Any brief remarks, ADM O'Neill, before we open it up?

Norman O'Neill: — I'll just limit it to recommendation no. 8 as the others are considered implemented. With regards to recommendation no. 8, the auditor just noted that our timeline was March 31st, 2026. So we also considered that implemented at this point in time.

The SHA does conduct supplier performance monitoring with a range of established practices including participation in vendor performance reviews led by 3sHealth [Health Shared Services Saskatchewan] for selected high value and critical contracts. This includes operational feedback from clinical and support areas on supplier performance related to service quality, delivery performance, and product availability.

Supplier performance information is also collected through operational reporting mechanisms including tracking of supply issues such as back orders, service disruptions, and other concerns identified by end-users. This information supports ongoing discussions with suppliers and informs internal contract management activities.

The SHA has developed a vendor performance complaint platform with impact rating and tracker standard dashboard reporting in AIMS [administrative information management system] and a performance survey for project completion. These practices provide meaningful input into supplier performance assessment and support informed contract management decisions across the organization.

Thus concludes my comments.

Chair Wotherspoon: — Thank you very much for the update there, the actions that have been taken. And I'd open it up to members if there's any questions on this chapter.

Joan Pratchler: — When we speak about services, are we talking for facility maintenance or does it include other kind of services in health care provision?

[11:30]

Carla Male: — Thank you for the question. My name is Carla Male. I'm the VP [vice-president] finance and chief financial officer, and purchasing of goods and services is a part of my portfolio. And so I'm glad to be here to assist in the questions. And the very short answer is it's both.

Joan Pratchler: — Would you be able to tell me what are the procurement policies regarding awarding of contract notifications?

Norman O'Neill: — Sorry, can you reiterate the question or repeat the question?

Joan Pratchler: — So when you put out an RFP [request for proposal] for service X, what are the policies about letting people know who won the awards or who the contract was awarded to? Sorry, that didn't even come out right but . . . [inaudible interjection] . . . Okay, good.

Carla Male: — Thank you very much for the question. We do notify both successful and unsuccessful proponents, or people that have made a bid on our RFPs, what their status is, once everything has been concluded.

Joan Pratchler: — And do any of those go through SaskBuilds, or it's just through the SHA for that process?

Carla Male: — Thank you for the question again. It's both. It's either SHA or 3sHealth depending on who owns the contract.

Joan Pratchler: — Okay. So I have a question regarding travel nursing companies engaged by SHA, you know, for the past while. Would you be able to tell us the top five companies and roughly how much were paid out to each?

Norman O'Neill: — So we don't have that information in front of us. We can commit to tabling it within 30 days. We'll get the top five up to the end of the fiscal year, so March 31st, 2026, if that meets your needs.

Chair Wotherspoon: — And just thanks, ADM O'Neill, for undertaking to get that information to the committee. Same process; the Clerk will lay out how to supply that to the committee. But thank you.

Joan Pratchler: — And could you also add the top 10 out-of-province care providers?

Norman O'Neill: — [Inaudible] . . . first. Just to follow up with your question, we're just seeking a bit of clarification, maybe an example of what you mean. So we're not quite sure what you're looking for.

Joan Pratchler: — So if a client needs to go to Alberta for services, who's that person or that company that provides out-of-province care for the various . . . I mean, that's why I'm saying 10, because you've got a whole bunch of health care provision outside of the province. We want to know who's providing them. And it's more for patient care. I'm not talking about equipment and things like that.

Norman O'Neill: — We'll just see what we've got.

Joan Pratchler: — Okay, thank you.

Ingrid Kirby: — Good morning. Ingrid Kirby, assistant deputy minister with the Ministry of Health. So your question on out-of-province providers, typically that is funded by the Ministry of Health and not the Saskatchewan Health Authority. So if a patient goes out of province — say to Edmonton — it's covered through reciprocal billing. It would be billed from Alberta to Saskatchewan, and we would pay for it through the Ministry of Health.

Joan Pratchler: — So you wouldn't be able to delineate the name of the service provider in that case?

Ingrid Kirby: — It would be Alberta Health Services.

Joan Pratchler: — Oh, Alberta Health Services.

Ingrid Kirby: — Yeah, the ministry only covers if it's a publicly funded facility, unless we have other arrangements in place.

Joan Pratchler: — Okay.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Thank you. SHA relies on pre-approved vendors on a regular basis or from time to time, I understand. I was wondering if you could tell me which pre-approved vendors you rely on, and what the process is for a vendor being pre-approved.

Andrew Will: — Sorry. Pressed the button. Andrew Will, CEO of the Saskatchewan Health Authority. Thanks for the question. So I wouldn't say it's a small component of our procurement. That would be a request for qualifications. It's usually more service related, where we post publicly an opportunity . . . competitive process for someone to provide their qualifications and services provided.

And then that would result in a list of pre-approved vendors that we would select based on what the particular needs at the time are. But goods and services are more requests for proposals and procurement processes that select particular vendors to deliver a product.

Hugh Gordon: — The second part to that question was like, what's the process for becoming a pre-approved vendor? Like why do you have them? How do they get selected? What's the rationale?

Andrew Will: — Yeah, and I appreciate that question. Maybe I wasn't just clear enough on that. So as I mentioned, really where that process would be used is more in terms of a service that the SHA might have a need for a particular company to provide consulting kinds of services. And those would be sometimes procured through the SHA, sometimes through 3sHealth as well.

And those are always publicly transparent in terms of posting those on SaskTenders and other means, so that people can then be aware of what our requirements are and submit their proposal for consideration, evaluation, and ultimately being awarded pre-

approved status.

Hugh Gordon: — Thank you. Maybe a question, a follow-up question for the Provincial Auditor. That was something that your office looked into as well, pre-approved vendors and the processes for approving them and managing them?

Tara Clemett: — Correct. So in terms of the follow-up here, like we're satisfied with all the procurement processes that the Saskatchewan Health Authority has in place in terms of the way things are being posted, the length of time, who's approving the purchases, the transparency, and all the recording of everything and such. So the only recommendation outstanding, they've since addressed with the supplier: basically evaluations.

Hugh Gordon: — I just want another follow-up here. Are potential suppliers evaluated on a case-by-case basis, or is it sort of an ongoing . . . is it a regular interval that they get evaluated?

Carla Male: — So if I could just ask for clarification. This is with respect to performance monitoring?

Hugh Gordon: — Yes.

[11:45]

Carla Male: — Okay. So I would say we do ask for performance surveys. We do ask for regular information from people who have contact with the vendors themselves. Certainly when a contract is up for renegotiation, that is a typical time where you can take a look at the performance and, you know, integrate that in what you're going to do going forward.

But having said that, we don't encourage people to wait until that point. If there's something critical happening or a conversation that needs to happen with a vendor so that it can improve for both parties, we would encourage frequent communication just to be able to resolve it in the moment. Thank you.

Hugh Gordon: — And then what action if any is taken when a supplier is found not to be performing at a satisfactory level?

Carla Male: — When there is evidence that there is non-performance . . . All of our contracts include key performance indicators and service levels that we have expectations for. It would begin with a conversation, but it can end with termination provisions that are in contracts as well.

Hugh Gordon: — Has any of that happened, or an instance like that occurred in the last . . . say, last year?

Carla Male: — Certainly I would say conversations have been had. That part is absolutely true. I don't have the data on, you know, termination for cause, but we never want to get to that point. It's the early intervention that really we rely on.

Hugh Gordon: — I know you had implemented a recommendation with respect to conflict of interest and put in place a system for that. I'm just curious if any member of a subcommittee, a tender subcommittee member has been found to be in conflict of interest, say, after a purchase was completed.

Carla Male: — I am not aware of any case.

Joan Pratchler: — No more questions from me.

Hugh Gordon: — I think we're good.

Chair Wotherspoon: — Any further questions from committee members on this chapter? Not seeing any, I'd welcome a motion to conclude consideration of chapter 13.

James Thorsteinson: — I'll so move.

Chair Wotherspoon: — Okay, we're going to move right along here and . . . Oh, sorry. Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. Okay, we'll move right along and turn our attention to chapter 14. I'll turn it to the Provincial Auditor.

Jason Wandy: — Thank you, Mr. Chair. The Saskatchewan Health Authority is responsible for the planning, organization, delivery, and evaluation of the health services it provides, including discharging patients from its hospitals. Discharging patients in a timely, safe manner is critical for effective bed management so beds are available when needed. If managed well, timely patient discharge can significantly improve bed access and patient flow.

Chapter 14 of our 2025 report volume 1 reports the results of our fourth follow-up audit of management's actions on the two remaining recommendations we originally made in 2015 about the Authority's processes for the safe and timely discharge of hospital patients from its two largest acute care facilities in Regina: the Pasqua and Regina General hospitals.

By February 2025 the Authority implemented the two remaining recommendations. We found the Authority used a team-based care approach at the Pasqua Hospital and continued to advance toward doing so at the Regina General Hospital through the negotiation of a new physician services agreement. Communication among team-based health care professionals provides complete information to help make informed decisions about in-hospital patient care and estimate timely and safe discharge dates for patients.

The Authority also implemented a process to audit the completion of medication reconciliations at both Regina hospitals. While the Authority found staff continued to inconsistently complete medication reconciliations upon patient discharge, it was committed to improving results in this area and periodically reported results to its board.

The Authority's report to the board in September 2024 indicated health care staff appropriately completed on average over 50 per cent of medication reconciliations audited across the province between July 2023 and June 2024. Consistent completion of medication reconciliations at patient discharge can help to reduce adverse drug-related incidents or unplanned hospital readmissions.

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

Chair Wotherspoon: — Okay, thank you very much for the follow-up. The committee's considered these recommendations. We've had the report of implementation that's occurred. Any brief remarks from the ADM before we see if there's any questions?

Norman O'Neill: — On this one, it notes that the intent of the recommendation has been met or implemented in all cases, so I'll leave comments on the table.

Chair Wotherspoon: — You bet. Any questions, folks? MLA Pratchler.

Joan Pratchler: — Thank you. What tools do you use to evaluate the efficacy of your collaborative in-patient care model?

Derek Miller: — So I'll just take the opportunity to just share a little bit of information about the model and then talk about how we're monitoring that. So the collaborative in-patient care model is operating in medicine units at Pasqua Hospital, where multidisciplinary bedside rounds and team-based care processes are in place. And the model uses unit-based care teams led by physicians and supported by nurses, pharmacists, occupational therapists, physical therapists, and other health care professionals working collaboratively on the same hospital unit.

The model supports regular multidisciplinary bedside rounds, improved communication among health care professionals, and coordinated discharge planning for patients. And we certainly recognize that effective communication and coordination among health care professionals involved in patient care is important for supporting safe patient care transitions, including timely discharge.

And as we've implemented that model, one of the ways that we evaluate or assess it is through Accreditation Canada, who's an independent national, even international, surveyor of health care organizations and assessing them against standards that have been established. And Accreditation Canada, they would be in a position to assess communication between providers, how we're documenting that, and how we're planning for discharges of patients, and the pieces of which are part of the collaborative in-patient care model. So it is a way for us to get feedback as well in terms of areas for improvement as we care for our patients.

Joan Pratchler: — So do I hear you say you rely on Accreditation Canada to inform the success of this?

Derek Miller: — That is one of the ways. I think operationally, locally they do monitor how a unit is performing on a more day-to-day basis, but otherwise no, I guess, formal evaluation of the model per se.

Joan Pratchler: — Are you considering doing that?

Derek Miller: — Currently that isn't part of our plan. Our intentions are . . . And as the Provincial Auditor found, we've been very successful at Pasqua Hospital. And there's improvements that need to be made at RGH, Regina General Hospital, in order to fully implement a collaborative in-patient care model. And that's our area of focus right now.

Joan Pratchler: — So do I hear you say it's sort of a pilot at this point and you're looking to move that model throughout the system?

Derek Miller: — It's not a pilot. It's implemented, and we have progressed considerably things like bedside rounding and multidisciplinary care planning at Regina General. As the Provincial Auditor found, there was a physician contract that needed to be addressed. And that's now been agreed to, which is allowing us to move forward with the remaining components of the collaborative in-patient care model at Regina General Hospital.

Joan Pratchler: — So that's only on the medical unit, or do the medicine units . . .

Derek Miller: — Those are on the medicine units, yeah.

Joan Pratchler: — Medicine units. And that's the only ones? Are you anticipating to have that moved throughout the other units or just there?

Derek Miller: — We have elements of the collaborative in-patient care model like multidisciplinary bedside rounding, team-based care as a principle, focusing on the patient, and involving the family in that rounding. So that is built in too, beyond just the medicine units that we're talking about?

Joan Pratchler: — Okay. Just further to that when this model was being, you know, thought about implementing, could you share with us the points in the process of that from inception to pilot to benchmarks, health care workers and patients were consulted in conceiving of that model?

Derek Miller: — The collaborative in-patient care model has been in place within Regina for a number of years now. It was initially brought in as a pilot within a unit. And at that time there was a lot of consultation with physician leaders, with staff, as well as patient family partners were engaged as it's very patient and family oriented. And so based on that feedback and the development of the model, it was implemented. And then since that time it has been expanded within the other units and then also to Regina General Hospital.

Joan Pratchler: — Thank you. Turning to MedRecs [medical reconciliation] at discharge, I noticed in the recommendation it addresses only acute care patients. So question no. 1 is, what percentage of MedRecs are now being actually completed for acute care patient discharge?

Norman O'Neill: — So this is something that we don't have right in front of us. But again this is one that we could probably get over the course of lunch and we'll try and table it after lunch, if that works for you.

Joan Pratchler: — Okay. And so acute care patients, you know, they've had their hip replacement. They're done, they go home; here's the prescriptions you need; check with your doctor.

The ones I'm really interested in is long-term care. So often there's challenges where they're discharged and MedRec finished, complete at the hospital. And then hopefully in the long-term care home they're re-evaluated at that point.

[12:00]

So the percentage of the MedRecs that are completed in acute care, I'm assuming is 100 per cent? What would be the MedRec completions for long-term care clients upon discharge?

Derek Miller: — Sorry. So just to clarify the question. And so we're going to follow up to provide you with the acute care discharges, the percentage that have a completed MedRec on discharge.

Joan Pratchler: — Can you add . . . Yeah.

Derek Miller: — And so you're asking within that, what portions are completed for those going to long-term care?

Joan Pratchler: — Two separate: acute care MedRecs percentage completed; long-term care MedRecs percentage completed upon discharge.

Derek Miller: — Sorry. On discharge from long-term care?

Joan Pratchler: — No. They've come in; Mrs. Smith has had a stroke. She goes into the hospital, goes through the process, is now going to be discharged. I assume her MedRec going back to that care home, if she came from a care home — acute care, now going to long-term care — that a MedRec is completed as well.

Derek Miller: — Yeah.

Joan Pratchler: — Are they subsumed in acute care? Or are they just from long-term care facility, hospital interim, and then back to long term?

Derek Miller: — So the first number that you asked for, which would be acute discharges, they would capture patients that would be discharged back to their home, with home care potentially, or they would be discharged to a long-term care facility. They would be captured in that.

Joan Pratchler: — Okay. Okay. Then that's fine. That would be helpful. Perfect. Thanks. That's all the questions I have.

Chair Wotherspoon: — No further questions over here. Any further questions, members? Not seeing any. Again I want to thank all those involved for the actions taken to implement these recommendations and the important work on these fronts. I would welcome a motion to conclude consideration of chapter no. 14.

James Thorsteinson: — I'll so move.

Chair Wotherspoon: — Okay. Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — Okay. I guess looking to my officials here, we'd like to get through 15 if we can. I think that's preferable than bumping it into the afternoon, because then it pushes everything back and who knows where we get to? Maybe we all get out of here at midnight or something. So are you okay if we focus in on 15 and hope to conclude its consideration before lunch?

Norman O'Neill: — Yes.

Chair Wotherspoon: — Okay. We'll turn our attention then to chapter 15, and I'll turn it back to the Provincial Auditor.

Jason Wandy: — Thank you, Mr. Chair. The Saskatchewan Health Authority is responsible for the planning, organization, delivery, and evaluation of the health services that it provides, including treating patients at risk of suicide.

In Saskatchewan over 200 people die by suicide each year. In the Authority's northwest service area, Indigenous people accounted for about 70 per cent of all completed suicides. Chapter 15 of our 2025 report volume 2 describes our second follow-up audit of management's actions on the six remaining recommendations we first made in 2019 regarding the Authority's processes to treat patients at risk of suicide in northwest Saskatchewan.

By February 2025 the Authority implemented the six remaining recommendations. We found the Authority analyzed key data about suicide rates and prevalence of suicide attempts to identify communities with the highest need for services. Its analysis resulted in adding key positions to two communities, North Battleford and Meadow Lake, to increase services to patients at risk of suicide.

The Authority also analyzed barriers to patients attending scheduled appointments — those appointments could be virtual or in person — and took steps to address the barriers, such as providing transportation options to patients. Our testing of 25 patient files admitted to emergency departments for suicide ideation, self-harm, or attempted suicide found the Authority conducted suicide screenings and psychiatric consultations when required. It also followed up with patients discharged from emergency departments to encourage further treatment where needed.

Finally the Authority required staff working with patients at risk of suicide to complete mandatory training and began tracking training completed by staff. It expected to provide staff with any missed training in 2025-26. Having effective processes to treat patients at risk of suicide in the northwest service area helps patients receive needed support and treatment.

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

Chair Wotherspoon: — Okay. Thank you very much for the follow-up here and this very important work and focus. I'll turn it over . . . We have the update here with the implementation and the actions taken. If there's any brief remarks before we see what we have for questions.

Norman O'Neill: — Just as the auditor has noted, all recommendations in this chapter have been implemented. So we'd be pleased to just go straight to questions.

Chair Wotherspoon: — Great. Committee members, any questions? MLA Pratchler.

Joan Pratchler: — Thank you. Regarding recommendation no. 1, is there a report on that? And if so, where is that accessible?

Julia Pemberton: — Thank you very much. Happy to be back. Julia Pemberton, vice-president for the North. So we did, as the auditor noted, complete the recommendations by engaging with multiple partners and multiple data sources to inform an analysis on ongoing service planning and resource allocation decisions, with a commitment to continuing annual review of suicide-related data to support alignment of services with areas of highest needs across the Northwest.

And we use this analysis to realign and enhance mental health and addiction resources in communities with higher identified need, including La Loche, Buffalo Narrows, Ile-a-la-Crosse, Lloydminster, Meadow Lake, and North Battleford. So it's an analysis, not a formal report.

Joan Pratchler: — Okay. Is there going to be a formal report?

Julia Pemberton: — We've used the analysis to inform our investments.

Joan Pratchler: — Okay.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Just wondering if you could tell the committee today what specific supports were implemented to each community designated as high risk in suicide attempts, and also if you could provide any statistics on suicide attempts in each community.

Julia Pemberton: — Thanks for the question. So we did add two psychiatric liaison nurse positions in North Battleford and two assessor coordinator positions in Meadow Lake. The data that we reviewed between April 2024 and February 2025 states there were 18 suicides in northwest Saskatchewan, compared with 28 earlier reported in 2018.

And then recent data from the coroner services indicates that there were 21 suicides in the Northwest in 2025, with five suicide deaths to May 19th in 2026.

Hugh Gordon: — Thank you.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — So new resources were allocated to those locations that you just mentioned? Those were new? They weren't reallocated from somewhere else leaving a gap in another location?

Julia Pemberton: — Correct.

Joan Pratchler: — What new mental health roles, if any, have been deployed to those high-risk areas?

Julia Pemberton: — Thank you for the question. Psychiatry services have been enhanced in the far North and include an additional twice-monthly clinic on-site visit based in Ile-a-la-Crosse and La Loche, as well as weekly enhanced virtual clinics to both sites.

Mental health nurse and counsellor positions to support mental health and addictions presentations in the emergency room specifically have been made permanent in North Battleford and Meadow Lake. That's in addition to the other positions in those communities. And we recently approved funding for a coordinator social worker position to support northern psychiatry clinics.

Joan Pratchler: — And are they fully staffed?

Julia Pemberton: — I can confirm that with you over lunch. Thank you.

Joan Pratchler: — Sounds good. Talk about training for the staff that's in northwest Saskatchewan. How often is the training going to be renewed, and how does the ministry plan to ensure training remains up to date?

Julia Pemberton: — Okay, thank you. All clinicians in the Northwest have received core suicide risk assessment training with additional specialized training delivered in high-risk areas, such as the former Keewatin Yatthé region, to strengthen response capacity. And recently the Saskatchewan Health Authority launched a suicide prevention program clinical standard in alignment with the Health Standards Organization's suicide prevention program required organizational safety practice.

A suicide risk assessment and management in mental health and addictions services' clinical procedure will be rolled out for training in the summer of 2026, and will be in effect by the end of the calendar year. A suicide risk assessment for non-mental health and addictions service lines' clinical procedures is in development and anticipated to be in effect early in the '27-28 fiscal year.

Clinical standards and clinical procedure learning modules are self-paced and on demand and will support the training required across the SHA.

Joan Pratchler: — Okay. Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — I'm wondering if you could share with the committee today how many patients have accessed and utilized psychiatric consultation.

[12:15]

Julia Pemberton: — Thank you for the question. We will endeavour to get an answer to you for the total number of visits for psychiatry across the province in 30 days.

Hugh Gordon: — And if I could ask you also to tag onto that what the wait times are for accessing those services, that would be great. Thank you.

Joan Pratchler: — What are some of the methods for SHA . . . Or what methods does the SHA use to provide on-call psychiatry?

Julia Pemberton: — Thank you for the question. We do have 24-7 psychiatry on call in Saskatoon and Regina. And all of our adult in-patient treatment centre beds have access to psychiatry

on call, 24-7.

Joan Pratchler: — So do I hear you saying that's telephone, Telehealth, or in person?

Julia Pemberton: — In person in the urban centres, but if you're outside the urban centres you would have telephone access.

Joan Pratchler: — Okay. So my question is regarding . . . Telehealth or telephone? I'm confused. Maybe I didn't hear you.

Julia Pemberton: — Telephone.

Joan Pratchler: — Okay, were there any barriers to that at all?

Julia Pemberton: — No.

Joan Pratchler: — And how many clients typically receive non-person psychiatry supports? You know, telephone or . . .

Julia Pemberton: — So how many clients receive virtual support for psychiatry?

Joan Pratchler: — Yeah, and how many . . . It sounds to me that urban has in-person but up north is not in person?

Julia Pemberton: — That's for the . . . so for on call. So if I'm a physician in a small — like in Nipawin — ER and I need to consult psychiatry, I can pick up the phone and call the psychiatrist on call in Saskatoon.

Joan Pratchler: — And so up north it's pretty much all telephone? Or is it in person?

Julia Pemberton: — We have in-person. So we've enhanced the in-person clinic coverage up in the far northwest.

Joan Pratchler: — What extent?

Julia Pemberton: — Twice. I just read that.

Joan Pratchler: — I did not listen, clearly.

Julia Pemberton: — No, that's okay. Let me just find it for you. So psychiatry services were enhanced in the far North and include an additional twice-monthly clinic on site, and that's in Ile-a-la-Crosse and La Loche. And it's augmented with weekly virtual clinics at both sites. So twice a month they're in person, but each week they have access. So it's in-person, virtual, in-person, virtual.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Yeah, I think it's recommendation no. 5 with respect to analyzing the reasons why patients are missing appointments for mental health services, out-patient services. I noticed that you said it was implemented, but I wonder if maybe you could put a little bit more detail into the actions that you were taking.

You mentioned there's a standardized no-show tracking process, corrective actions introduced, including appointment reminders, etc. But with respect to that recommendation, what analysis of those reasons was conducted, and what are some of the reasons you can share with us that were prevalent that . . . I mean obviously you're addressing them. I'm just curious what you were addressing, what reasons you were addressing.

Julia Pemberton: — So as you mentioned and you're aware, we did develop a work standard that was developed and deployed that required staff to follow up with patients who miss appointments, document contact attempts, and also record reasons for non-attendance using a standardized no-show data collection tool. So we're able to provide that data for you. We use this data to analyze and to implement targeted actions to address barriers, including encouraging patients to confirm, cancel, or reschedule appointments; improving communication of appointment details; and providing transportation support, such as taxi vouchers and staff-assisted transport where required.

We do have data from 2024 and 2025 that show the reasons for missed appointments. The largest reason in 2024 at 49.3 per cent is the patient forgot. That was reduced with the actions we implemented in 2025 to 29.4 per cent, still being the largest reason for missed appointments.

Hugh Gordon: — And I imagine transportation was a barrier you identified. And I guess generally speaking, since you implemented this — it doesn't say when you implemented this, if it was early in this new year — if you had any noticeable improvements on show-up time for these appointments?

Julia Pemberton: — Transportation was also tracked as a reason. You're correct. And it was around 4 per cent in 2024 and 8 per cent in 2025.

Hugh Gordon: — So it went up. Okay.

Julia Pemberton: — So we continue to monitor these and implement additional actions in a quality improvement framework.

Hugh Gordon: — Okay. Thank you.

Chair Wotherspoon: — Not seeing any further questions on this chapter. I'd welcome a motion to conclude consideration.

James Thorsteinson: — I'll so move.

Chair Wotherspoon: — Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We're 12:23 here. You guys want to go at 1 o'clock as planned? Do you need 1:15? I'm looking to committee members, officials, the auditor, the comptroller as well. 1:15, nod. 1 o'clock? What's your pref, folks?

A Member: — 1:15.

Chair Wotherspoon: — Okay, let's convene again at 1:15.

[The committee recessed from 12:27 until 13:17.]

Chair Wotherspoon: — Okay, folks, we'll reconvene the Standing Committee on Public Accounts. And we're going to turn our attention to the considerations before us on the agenda this afternoon. And we're going to start with a new chapter with new recommendations, that being chapter 6 from the 2025 report volume 2. And I'm going to turn it over to the Provincial Auditor for her presentation.

Jason Wandy: — Thank you, Mr. Chair. Chapter 6 of our 2025 report volume 2 describes the results of the annual audit of the Saskatchewan Health Authority for the 2025 fiscal year. We found the Authority's financial statements were reliable, and it complied with the authorities governing its activities related to financial reporting and safeguarding public resources.

Additionally the Authority had effective rules and procedures to safeguard public resources other than the three new recommendations described in this chapter. The Authority also implemented three of our previous recommendations during fiscal 2024-25. It finalized the remaining key aspects, such as security or disaster recovery requirements, of its IT service level agreement with eHealth Saskatchewan, improving its ability to effectively monitor eHealth's provision of IT services.

Additionally while the Authority continued to work toward fully implementing the administrative information management system, or AIMS, it shared lessons learned with other government agencies leading significant IT projects. Doing so can help avoid system implementation failures on similar IT projects.

The Authority's implementation of AIMS also enabled it to appropriately separate incompatible duties when setting up vendors and paying staff. On page 42 we recommend the Saskatchewan Health Authority regularly monitor whether users with conflicting roles process payment transactions without involving others.

Our review of Authority user access in AIMS identified 19 users with the ability to enter and approve invoices. We found the Authority did not have established practices to monitor whether users with these conflicting roles processed payment transactions without involving others. Our analysis of 2024-25 financial data in AIMS did not identify any inappropriate payment transactions where the same user entered and approved an invoice.

Lack of data analytics or reports to regularly monitor whether users with conflicting roles processed payment transactions without involving other individuals increases the risk of the Authority processing inappropriate financial transactions or not catching errors or fraud.

On page 43 we recommend the Saskatchewan Health Authority prepare and review sufficient financial reconciliations. AIMS created challenges in preparing sufficient and timely financial reconciliations for accounts receivable, payroll, and cash, given the Authority's inability to obtain detailed reports from the general ledger.

We examined 31 bank reconciliations the Authority completed throughout fiscal 2024-2025 and found 21 not prepared or reviewed timely — that is within seven weeks of month end — during the year. We also identified unreconciled differences in 4 out of 14 bank reconciliations we tested at March 31st, 2025. The unreconciled balance for these four reconciliations totalled about $6 million. As of April 2025 the Authority was working to reconcile the differences and correct the financial records where necessary.

We also found two instances where payroll reconciliations and two instances where accounts receivable reconciliations were not done timely during 2024-25. Regular reconciliations check the accuracy and reliability of accounting records. Consistent preparation and review of sufficient reconciliations help to identify issues and allow for corrective action in a timely manner.

On page 44 we recommend the Saskatchewan Health Authority consistently maintain approved timecards to support payroll amounts. Payroll is the Authority's largest expense, amounting to over $2.7 billion in fiscal 2024-25, including over 200 million related to overtime pay. We tested 80 payroll transactions for both in-scope and out-of-scope staff and found over 25 per cent of the timecards we tested lacked appropriate approvals, including 21 instances where the Authority was unable to provide timecards.

The Authority expects staff to complete manual timecards to help track and record hours worked. However the Authority was working towards implementing electronic timecard approvals. Doing so should create efficiencies and help the Authority keep better records of timecard approvals. Timecard approval is an important step in managing employee attendance and making sure staff get paid accurately for time worked. It is one of the final checks to help ensure payroll calculations are based on accurate and approved time records.

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

Chair Wotherspoon: — Thank you very much for the focus of the chapter and the new recommendations. I'll turn it over to ADM O'Neill for a brief response, and then we'll see where questions are.

Norman O'Neill: — I'll just touch on recommendations 2, 3, and 4, which are new. I believe the others are considered implemented.

So starting at recommendation 2, which is in regards to the SHA regularly monitoring whether users with conflicting roles process payment, the SHA has implemented system-based monitoring processes to identify segregation of duties and conflicts. Access controls are configured to restrict payment processing to authorized users who do not have conflicting entry or approval roles.

The SHA conducts periodic reviews of system access to identify and address conflicts in user roles and permissions. Where conflicting roles are identified, corrective action is taken, including removal or adjustment of system access. A formal process for routine segregation of duties, reporting, and review of conflicting roles will be developed. User requirements will be reviewed to reduce the number of users with conflicting roles where possible by September 30th, 2026, and reports will be developed by June 30th, 2026 and reviewed monthly to ensure users with conflicting roles are not processing payments without involving others.

Surrounding the recommendation for the SHA to prepare and review sufficient financial reconciliations, we consider this recommendation fully implemented at this time internally. The SHA recognizes that timely and complete financial reconciliations are required to ensure accuracy and reliability of financial records. The SHA treasury team has implemented defined timelines requiring bank reconciliations to be completed within six weeks of month end, with approvals finalized by week seven.

SHA corporate reporting has implemented a reconciliation tracking process that assigns clear ownership for all accounts requiring reconciliation. Standardized templates and documentation requirements have been introduced to improve consistency and quality of reconciliations.

Payroll and accounts receivable reconciliation processes were strengthened through improved tracking, monitoring, and follow-up processes. Monthly monitoring is in place to track completion status and address overdue reconciliations, and full completion with reconciliation timelines was achieved on March 31st, 2026.

The final recommendation I'll touch on is for the SHA to consistently maintain approved timecards to support payroll amounts. The SHA recognizes that approved timecards are required to support accurate payroll processing and validation of employee hours worked. Managers are responsible for reviewing and approving timecards within existing systems until new time validation and scheduling functionality can be implemented.

Payroll sends out regular communications to reinforce timecard approval requirements and manager accountability. Monitoring processes are in place to identify missing or unapproved timecards, and follow-up happens with responsible managers.

And thus concludes my comments.

Chair Wotherspoon: — Okay, thank you. And thank you for the status update as well. Just to clarify, I guess we have three brand new recommendations. Then we have the couple outstanding ones as well, where there's been . . . you've reported implementation on those fronts, correct? And then three new recommendations that are new to this committee here today, just for members and everybody to have a sense of that. And at this time I'll open it up to committee members for questions. MLA Gordon.

Hugh Gordon: — Thank you. It looks like the timeline for the implementation of the timecard approvals, the third new recommendation there, it looks to be end of fiscal year '27-28. I was just wondering if you could explain for the committee why it's going to take that much longer to fully implement that recommendation.

Mike Northcott: — Good afternoon. My name is Mike Northcott. I'm the chief human resources officer here with the SHA. So right now we're working on a replacement for the time validation and scheduling technology solution. So we do need to go through that process. And the existing processes will be in place until that new consistent time validation technology solution and processes are put in place.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — And that's going to take two years?

Mike Northcott: — We're on the front end of that. We're actually evaluating the products next week. We have some good engagement on that. So once we have the vendor identified, then we'll be able to determine a more precise implementation path and time frame. But that's where we are right now.

Joan Pratchler: — And that's still with eHealth?

Mike Northcott: — SHA is leading that.

Joan Pratchler: — I'd like to talk a little bit about AIMS. Can you share any details about the findings of the lessons-learned document? And which agencies in the government was it shared with?

[13:30]

Mike Northcott: — So that was a process that's led by 3sHealth. So they did present it to the steering committee, which a number of us are on. So the steering committee includes the SHA, 3sHealth, eHealth, Ministry of Health.

Some of those themes were increased user acceptance testing and engagement of end-users throughout. So those are some samples of those high-level themes there. But I don't have the report with me to go into that level of detail, but 3S [Health Shared Services Saskatchewan] would have that information.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Just on that point, like you had mentioned that you're going to be utilizing a system, a rollout, the front end, the rollout of a new scheduling solutions program for your timecard approvals. I take it that's not AIMS.

Mike Northcott: — No, that's not AIMS.

Hugh Gordon: — Was that not what AIMS was supposed to do?

Mike Northcott: — That was a component of AIMS, but that part of the components was . . . We stopped utilizing that. And so now we're going back and doing assessment of, okay, what is that solution moving forward, and really looking at what are the solutions that have the functionality that we need across Canada, and what do we already have in terms of licences and that sort of thing.

Hugh Gordon: — What is that going to cost though? Like AIMS was initially billed at $80 million. It then became $280 million. And now you're not relying on it for payroll, for example, or scheduling apparently — scheduling, time card approvals. So what's the cost of this going to be?

Andrew Will: — So we will be disclosing in our financial statements the cost of the functionality that we were not able to use. There were several components within the AIMS software to do different functions for the SHA. We were able to successfully implement all the core systems including finance, HR [human resources], supply chain. The only component that

was not successful was employee scheduling.

So as Mike said, currently as a part of that program we did have access to licensing for two different products that we're currently assessing to see if they will meet our needs. We'll be looking at, you know, the extent to which they're compliant with our collective agreements. What we'll be looking at: are they user-friendly, functional for our staff in terms of the usability of those two products that we do currently have licensing for? And then looking at, you know, will there be any workarounds required as we do leverage one of those two solutions that we do currently have licensing for?

But there was one component in terms of a CleverAnt product that was really intended to deal with some of the complexities of the different collective agreement requirements that we had. And that part was the component that we had to abandon, and now look at an employee scheduling solution from the licensing that we have.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Well just as a follow-up then, I would hope it's like AIMS, with this new system. Like if it's off the shelf . . . AIMS was off the shelf apparently and it ended up having to be customized to amalgamate 80-some different legacy systems. So now you're talking about another off-the-shelf product that might need extra customization.

Andrew Will: — So there were different components of AIMS. Some of them were, as you say, off the shelf, so Oracle, UKG, a product — actually a Saskatchewan product — called Andgo that were part of the collective solution. There was an additional product that was more of a customized component, and that software was called CleverAnt. And that was, as I mentioned, meant to kind of knit those different systems together and then address some of the collective agreement complexities.

And that was the component that was not user-friendly for the people that were doing scheduling and for our staff. So you know, we made the decision to say, look, this is not meeting our expectations; now we're going to revisit the off-the-shelf solutions that were part of the licensing with AIMS, and see are there other ways that we could do this and not rely on the CleverAnt product.

Hugh Gordon: — The follow-up there on MLA Pratchler's question was with respect to this lessons-learned report and the details of those lessons learned. And I would imagine these payroll-scheduling issues, all these other issues that you had in marrying up those old systems to the AIMS system, would be part of those lessons learned. You're not able to share any of those lessons here today with us?

Andrew Will: — So thanks for the question. And we don't have the document here with us today. So what I would say is 3sHealth was the lead organization that developed that report with input from, you know, all the stakeholders that were involved. We could endeavour to reach out to 3sHealth and get the key themes of the findings from that report and then provide that within 30 days.

Hugh Gordon: — Or perhaps we could ask you to table that report. Is that possible? Are you able to table that report for the committee?

Andrew Will: — So as I mentioned, 3sHealth is really the organization that's the owner of that report. We'd have to follow up with them but we would endeavour to do that.

Hugh Gordon: — Sorry, I'm a little confused. This is a report for SHA for the Ministry of Health, right? This is a report that they did — lessons learned. This is what you guys commissioned 3sHealth to do for you. You're saying they're the beneficial owner of that report? You are not the owner of that? How can you get any lessons learned on your end if you're not an owner of that information?

Andrew Will: — Well I'm just saying 3sHealth is the organization that developed that. They were leading the AIMS implementation on behalf of the entire health system. The SHA is one of the users of that system, but we're not the only user of that system. So input would come from SHA but also other organizations as well. I'm just saying, you know, we're happy to reach out to 3sHealth — they are the ones that produced the document — and pass on the request in terms of providing the report or key findings from the report.

Hugh Gordon: — Okay. What would be a sufficient amount of time to do that, do you think?

Andrew Will: — Thirty days.

Hugh Gordon: — Thirty days?

Chair Wotherspoon: — Yeah, thanks. And I appreciate on these kind of questions, you know, where there's multiple parties and ministries involved, the public dollars involved. And it's public performance involved as well. To the best of your ability it's nice to deal with the facts that we're able to at this table. Because obviously if we don't get the answers that are here, that are, you know, important on these fronts, then the committee may need to look at, well who do they need to go to and have before this committee to get that information before us? So I appreciate trying to be as forthright as one can to make sure that the answers and information is provided.

More questions? MLA Pratchler.

Joan Pratchler: — So just circling back. So AIMS was, for lack of a better term, outsourced to eHealth to create?

Andrew Will: — No. 3sHealth, which is our health shared services organization, was the leader that basically oversaw the initiative. They held the contract directly with Deloitte, who is our systems integrator for the project.

Joan Pratchler: — So eHealth had nothing to do with AIMS?

Andrew Will: — eHealth was part of the steering committee in terms of oversight for the project. There were some aspects that eHealth helped support in terms of, for example, terminals for people to be able to access that software through. But eHealth was not the organization that led the project.

Joan Pratchler: — Okay. So do I hear you saying Deloitte was

the one that created AIMS?

Andrew Will: — I'm saying that Deloitte was the systems integrator that brought the different solutions that they were contracted to do that, and supported the integration of those different systems to meet the needs that had been defined by the health system.

Joan Pratchler: — So I just want to ask another question about the Sask product angle. Can you tell me more about that?

Andrew Will: — Yes. So there was a product developed quite a number of years ago by the former Saskatoon Health Region that helped automate being able to offer shifts out to employees and then they could accept that electronically. And so as a part of this solution we were very pleased that that product is part of the collective solution.

And we still have that available to us as a part of meeting the needs of the health system. So yeah, we're really proud of . . . And actually at the time there was a partnership between the former Saskatoon health region and I think the company's name was Noodle Cake at the time that partnered together to create that product.

[13.45]

Joan Pratchler: — And so who is navigating the coordination of all this again? Is it going to be Deloitte again? Is this AIMS 2.0?

Andrew Will: — So the AIMS project has closed out. It's ended; it's done. As I mentioned, all of the functionality was successful — finance, HR, supply chain — with the exception of employee scheduling. So we've closed that project out.

Now the SHA will be leading the solutioning for employee scheduling and time entry. So that will be us directly. And I'm confident that our team will find a positive solution for that.

As a part of that work, we're also going to be looking at what is the model to support front-line managers in terms of how they schedule staff as well. And you know, can we see a little bit more of . . . Another learning for us was a decentralized approach where schedulers are a little closer to the facilities and they know the staff and they know the facility. So we'll be looking at two things: what's our process for supporting managers in scheduling employees, but also what is the technical solution that we can use. And our goal will be find an off-the-shelf solution, first looking at the two that we have licensing for currently.

Joan Pratchler: — Okay, so SHA isn't developing its own IT system to make . . .

Andrew Will: — No. We will not be doing that. No.

Joan Pratchler: — Let's not. Yeah. Okay, good idea. Yeah, good.

Chair Wotherspoon: — Who's on the steering committee that you referenced with respect to guiding the project? You mentioned that eHealth was on the steering committee. Who else was on that steering committee?

Mike Northcott: — There were eHealth, 3sHealth, SHA, Ministry of Health, Cancer Agency.

Andrew Will: — Oh and we have an affiliate representative.

Mike Northcott: — Oh yeah, an affiliate representative.

Chair Wotherspoon: — Thank you.

Mike Northcott: — If I could just follow up on previous questions around the report and some of those areas. We did find some further information, so I just wanted to share that.

So the extent of system testing, so end-to-end testing was a theme. User training, so timing of when that training is done, tailoring it to address the different needs of the different user groups. Go-live preparations, so all the pieces that go in to go live — cut over to the new system, management of technical support once launched. And project management lessons learned, so data quality review and sign-offs. And then technology management lessons learned, so engaging business stakeholders early in the program.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — So those seem like pretty basic IT metrics to have in place before you even start a massive project like that. Were they?

Mike Northcott: — Those are the themes. So those are the buckets. So there's more detail within those buckets, right, around improvements. So for instance user training, there was user training done. But can we improve? Is there ways to improve that training, such as the time that that's delivered, maybe how it's delivered, those types of things.

So it's not saying that we didn't do training. We did. I was there; I took it. But is there areas where we could have, you know, in retrospect and doing next time, is there ways to improve those areas?

Joan Pratchler: — That's just my reflection on that. It's a massive, massive project that had several overruns, not minimal, that those would have been up front, things you would kind of do on a pilot project before you throw it out through the whole thing. I don't know. It just seemed odd. I didn't understand why.

Mike Northcott: — Well like I said, that's high-level areas that I'm talking about, right? So the training as the example, we did training. When you go through an implementation, in retrospect there's always things that you could say, oh you know, we could improve upon that if we did this tweak. So it's not saying that we need to . . . Oh, you know, we did training. It's just how do we improve upon that.

Chair Wotherspoon: — Any further questions, committee members?

So we have three new recommendations before it. To make sure I understand properly, I think we have reported out that we have progress on recommendations 1 and 3 and compliance, implementation with respect to recommendation 2. Is that correct?

Norman O'Neill: — That would be the auditor.

Chair Wotherspoon: — The auditor comes in and she'll assess whether you've done what you've said you've done and whether that fully satisfies the . . . But right now from your perspective, this is what you've reported out to us, I believe. Does that capture it?

Norman O'Neill: — It does capture it. I was just mixed up on process.

Chair Wotherspoon: — No, that's good, that's good. Yeah, she'll come, and that's a good thing. I know we have thousands of people that tune in to watch the Public Accounts from every corner of Saskatchewan. And for those that are watching, it's good for them to actually know we actually have a really thorough follow-up, right?

So we get, you know, the information that's supplied here. We get the perspective shared from the ministry, and then there is a follow-up again by the auditor. And in fact we track all the way through and keep bringing those recommendations back before this committee — over many years if there's not resolution or compliance.

But I'm sure that in this case here, what you've shared will also be confirmed by the auditor. And you know, as you move forward and take those other actions that will get those recommendations into compliance, these will come off our work list here, the follow-up. But it's a good follow-up process that we have here as Public Accounts in working with the auditor and of course the lead work of the ministry and agencies.

At this point then I'd welcome a motion to concur with recommendations 1 and 3 and note progress.

James Thorsteinson: — I so move.

Chair Wotherspoon: — Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. And with respect to recommendation no. 2, that we concur and note compliance.

James Thorsteinson: — I so move.

Chair Wotherspoon: — Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That guy's got a heck of a batting average here with those motions he brings. So turning our attention now, we've got a few more items on our agenda her today, some important chapters. They're all follow-up chapters that have been considered here at the table before, and I'm going to turn it over to our Provincial Auditor once again to focus now on chapter 26.

Jason Wandy: — Thank you. The Saskatchewan Health Authority uses private operators of special-care homes to provide 24-hour care to those Saskatchewan residents who can no longer care for themselves. In 2024-25, the Authority contracted 15 special-care homes in Saskatoon and surrounding area for a total cost of just over $127 million.

Chapter 26 of our 2025 report volume 2 describes the results of our third follow-up of management's actions on the four remaining recommendations we originally made in 2017 regarding the Authority's processes to oversee contracted special-care homes in Saskatoon and surrounding area.

By June 2025 the Authority implemented the four remaining recommendations. The Authority signed new contracts in 2024 with each of the 15 contracted special-care homes clearly outlining the accountability relationships between the Authority, the special-care homes, and the Ministry of Health.

The Authority also established and included performance measures and targets, service expectations, and reporting requirements in the new contracts. Our testing of signed contracts for three special-care homes in Saskatoon and surrounding area found each contract included the expected requirements. The new contracts should help the Authority in assessing each home's compliance with the ministry's *Program Guidelines For Special Care Homes* and work toward improving the overall quality of resident care within these homes.

While we found special-care homes in Saskatoon and surrounding area continue to not meet all performance targets for quality care, they improved their results since 2023. Although results worsened for one measure — that is, newly occurring pressure ulcers — results improved for four measures, those being residents in daily physical restraints, use of antipsychotics, pain management, and residents with depression.

The Authority works with special-care homes to address non-compliance with performance measures related to the quality of resident care, including the option of entering into a co-management agreement if a home continuously fails to comply with the guidelines. We found the Authority entered into a co-management agreement with one special-care home in Saskatoon since our 2023 follow-up audit due to a significant non-compliance breach.

The Authority also requires homes to provide quarterly reports on their achievement of performance measures and targets, as well as associated corrective action plans to address any areas of non-compliance. Effective oversight of contracted special-care homes allows the Authority to make sure the overall quality of resident care in special-care homes is reasonable and appropriate and aligns with the guidelines.

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

Chair Wotherspoon: — Thank you very much for the follow-up and the focus of this chapter. I'll turn it over to ADM O'Neill for a brief remark, and then we'll open it up for questions.

Norman O'Neill: — I'll just note that we agree with the auditor's assessment that all of these actions have been implemented, and we would be pleased to take questions.

Chair Wotherspoon: — Okay. Right on. Committee members,

any questions? MLA Pratchler.

Joan Pratchler: — Would you be able to share some of the details about the contracts signed with the 15 care homes? Would they all be a single contract just delivered in 15 different care homes? Or are they separate contracts set out for each individual?

Derek Miller: — Each of the affiliate partners sign a principles-and-services agreement, which is the contractual arrangement, and they're individual contracts between the SHA and that particular care home.

Joan Pratchler: — And can you talk a little bit about the responsibility that falls on the care homes and the responsibilities that fall on SHA to ensure that, you know, the contract is fulfilled properly?

Derek Miller: — The contract outlines the service requirements, the types of beds and care that is provided by each of the care homes. They're independent organizations, and so they're responsible for the management of their day-to-day operations, their planning, budgets, and so on. And then we provide funding to them in order to deliver those services.

From the SHA, we are responsible to oversee the delivery of those services. There's a number of requirements within the agreement, such as quality indicators, that they monitor and report to us. We perform site visits on a weekly basis to the homes so we have a good understanding of what is happening in each one of the facilities. And then if there are incidents or Ministry of Health visits and inspections that require follow-up, we provide oversight for those as well.

Joan Pratchler: — So it was mentioned that there was one facility that didn't meet the, you know, targeted expectations. And the result of that was increased training or transfer of care provision to SHA?

Derek Miller: — There was one affiliate where we entered into a co-management agreement with them based on concerns around some quality-of-care concerns and service delivery. And the co-management agreement basically allows the SHA to take control of the day-to-day operations as well as to direct improvement actions within the care home. And we work with the leadership. We provide on-site support in order to address any of the concerns. And once they're able to demonstrate over a period of time that they're meeting the standards, then we end the co-management arrangement.

Joan Pratchler: — And I notice this mentions only Saskatoon and surrounding areas. Has that expanded to the rest of the province?

Derek Miller: — Yeah, the principles-and-services agreement that we use for our long-term care affiliates are consistent, and they have a consistent template for all of our long-term care affiliates. The differences would be in terms of the number of beds and the level of care that they would be providing and the funding that would go with them. But otherwise, across the province we have a standard principles-and-services agreement.

Joan Pratchler: — And would you find the same level of success across the province as well?

Derek Miller: — Yeah, the implementation of the principles-and-service agreement over the last two years has been very helpful for us in terms of establishing clear expectations for service delivery, for monitoring, reporting, and follow-up. It's been a significant improvement and it addresses a lot of the issues that the Provincial Auditor identified for Saskatoon. We had similar types of challenges elsewhere in the province, so we've now been able to standardize from a continuing care perspective.

Joan Pratchler: — And in terms of funding, I know there were issues in years past that regional facilities received a different kind of funding or amount of funding than affiliates. Has that been all evened out and equitable now?

[14:00]

Derek Miller: — With the principles-and-services agreement that we have recently entered into, there was additional funding provided by the Ministry of Health because there was a variation in the province from the former regional health authorities in terms of the funding provided to affiliates. And so part of the ministry process considered funding levels within SHA to operate facilities — as well as affiliates — and established a consistent and standardized approach to how money would be provided for affiliates.

Joan Pratchler: — Thank you. And I'm sure the affiliates appreciated that very much. Yeah, that's all my questions.

Chair Wotherspoon: — Thank you. Looking to committee members that may have other questions. Not seeing any, I'd welcome a motion to conclude consideration of chapter 26.

James Thorsteinson: — I so move.

Chair Wotherspoon: — Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We're going to move right along and turn our attention over to the auditor to focus on chapter 27.

Jason Wandy: — Thank you, Mr. Chair. The Saskatchewan Health Authority provides mental health and addictions services in Prince Albert and surrounding areas through in-patient, such as in hospital or recovery centres; out-patient, that is, day programming; and community rehabilitation and residential services. The Authority provides most of these services in the city of Prince Albert.

Chapter 27 of our 2025 report volume 2 describes our third follow-up audit of management's actions on the two remaining recommendations we first made in 2018 regarding the Authority's processes to provide timely access to mental health and addictions services in Prince Albert and surrounding areas. By July 2025, the Authority implemented the two remaining recommendations.

We found the Authority developed a provincial strategy to implement a mental health and addictions IT system that records key information in a single client file for mental health and

addictions services provided in out-patient and in-patient settings. The Authority has a provincial work plan for implementing the IT system and expects all mental health and addictions services to be using the system by March 2028.

Having a single client file that includes all mental health and addictions services provided to a client will better help health care providers in determining the next appropriate course of action for clients.

Additionally, we found the Authority sufficiently collaborated with the Ministry of Social Services to enhance access to housing for mental health and addictions clients living in Prince Albert. The Authority also signed a data-sharing agreement with various agencies such as the ministries of Corrections, Policing and Public Safety, Social Services, and Health, as well as the Saskatchewan Housing Corporation, to share certain data to support the government's provincial approach to homelessness or PATH initiative which is an integrated response to address the increase in chronic homelessness.

The Authority planned to monitor the initiative through various outcome indicators such as the number of clients referred to supportive housing and utilization rates for shelters. Having and monitoring outcome indicators is important as it can help the management make informed decisions and may lead to better outcomes for people living with complex mental health and addictions issues.

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

Chair Wotherspoon: — Thank you very much for the presentation and the follow-up on this front. I think this originally was from the 2018 report, I think, the recommendations. Thanks as well for the actions that have been reflected by the ministry. I'd open it up for a brief remark from ADM O'Neill and then see if there's questions.

Norman O'Neill: — Just similar to the previous chapter, we agree with the assessment of the auditor that the recommendations have been implemented, and we'd be pleased to take questions.

Chair Wotherspoon: — Okay. Looking to committee members that may have questions. MLA Gordon.

Hugh Gordon: — Thank you. I just wonder if you could share with the committee today how the implementation of the MHAIS system has assisted in providing mental health services to patients in those areas, and also how that might have even helped health care providers in providing those services.

Julia Pemberton: — Thanks for the question. Happy to be back. So the mental health and addiction information system does allow health care professionals to access the complete client history, improving the clinical decision making and the continuity of care as well as the coordination between in-patient and out-patient services. At the core of the SHA strategy is the implementation of the mental health and addiction information system. This provincial IT platform captures key patient information into a single integrated electronic record across in-patient and out-patient settings.

The single and central system helps to ensure that relevant and timely patient information is readily available to coordinate patient care. To date, the mental health and addiction information system is used in all SHA in-patient mental health acute care facilities, used in all SHA out-patient mental health and addictions programs across the province.

Hugh Gordon: — Thank you. The auditor also noted in her report that stable housing could lead to better outcomes for people living with complex mental health and addictions issues. I also noted that there was an announcement of 155 supportive housing units, 120 emergency shelter, 30 complex needs shelter spaces. And I'm just wondering, you know, how many mental health and addictions clients have been given access to housing either through those facilities or through the PATH initiative? If they're all the same, forgive me for confusing them.

Julia Pemberton: — So thank you for the question. We really want to acknowledge that the collaboration between health and social service systems is intended to improve the stability for individuals with complex needs such as mental health and addiction, and that stable housing is recognized as a key factor in improving mental health and addiction outcomes and reducing repeat crisis service use.

The integration of housing and health care data better supports planning, targeting of services, and evaluation of system performance. The SHA also continued participation in the Reaching Home community advisory board in Prince Albert, supporting homelessness reduction strategies and youth housing initiatives. In November 2024 this resulted in an agreement with the community-based organization to add five additional youth housing spaces for individuals affected by mental health and addiction challenges.

The SHA collaborated with the Ministry of Social Services to improve access to housing supports for individuals experiencing mental health and addiction challenges, and in November 2023 the Government of Saskatchewan launched the provincial approach to homelessness — PATH — initiative.

This initiative focuses on addressing chronic homelessness through coordinated housing and support services. PATH includes commitments to expanding support housing, emergency shelter spaces, and complex needs and shelter capacity across multiple communities including Regina, Saskatoon, Prince Albert, and Moose Jaw.

And to get access to this supportive housing there is a standardized assessment tool to apply to the criteria for accessing the housing. This tool was developed in collaboration with Social Services, the Ministry of Health, and the SHA, but at this time we can't identify a certain number of people with mental health and addictions who are accessing housing because that tool is for all people who need that housing, not just mental health and addictions clients.

Hugh Gordon: — Just as a follow-up on that. Stable housing has been identified as a key factor in improving the outcomes for people dealing with complex mental health and addictions issues, and this is . . . You guys have got now a coordinated approach with Social Services on this.

I would really hope that the Authority is interested in those numbers, because that's going to give you a really good indication as to whether or not you've got people that are falling out of the program or having difficulties staying in addictions treatment or attending counselling sessions, whatever the case may be.

Like the whole success of your program depends on that partnership. So I would really hope that you would have that information. And I know that wasn't the purview of the Provincial Auditor here, but I would think that would be very important information for you guys to have. And I'd love for you to be able to share that at some future point so that we could start to measure the outcomes better. Correct?

Correct me if I'm wrong. Correct me if I'm totally off base in that line of thinking. But if this is . . . And I'm just saying this because, you know, I've attended meetings in Prince Albert with key stakeholders on this issue, and housing is a major issue in an area like Prince Albert when it comes to mental health, addictions, all kinds of other socio-economic factors that have impacts beyond that. It has impacts on the business community. It has impacts on the neighbourhood, on all kinds of things, the quality of life.

So that's why I'm asking you that question, and I really hope that you would begin to track and measure that in a more robust way. Thank you.

Joan Pratchler: — So my follow-up question is, do you or do you not or do you have access, some way to tell us how many spaces have been secured for clients in each of the years '23, '24, '25, and Q1 [first quarter] of '26?

[14:15]

Julia Pemberton: — Appreciate the question. And totally agree that housing is integral to the success of our clients with mental health and addictions, along with other clients that the SHA serves. Housing continues to be a need that, in any interaction with our services, we are asking about housing and we are working with the partners identified in PATH and other services to make sure we secure housing for our clients.

We do currently have a partnership with PATH for 100 spaces. Those spaces use that standardized assessment criteria to access, so not only for mental health and addictions but could be for other reasons. And we currently don't track out of those 100 spaces how many specifically are related to mental health and addictions.

Joan Pratchler: — Are all of those 100 spaces used?

Julia Pemberton: — Yes.

Joan Pratchler: — Oh, okay.

Julia Pemberton: — They're all full.

Joan Pratchler: — Okay. And there's need for more? What's the waiting list, do you know offhand?

Julia Pemberton: — I don't.

Joan Pratchler: — Okay.

Hugh Gordon: — Just a quick follow-up here with respect to the reporting on that. The auditor's report had mentioned, I believe on page 260, that you expect to begin reporting on the PATH initiative and client indicators in late 2025. So I'm just wondering like what are you going to be reporting on then if you're not keeping track of client numbers that are utilizing PATH?

Julia Pemberton: — Thank you for your reference to page 260 in the auditor's report, specifically figure 1, examples of approved outcome indicators from the PATH data-sharing agreement. We do acknowledge your previous comment that it says that we will begin reporting on the PATH initiative's client indicators in late 2025, and we are still in the process of initiating that reporting with PATH and Social Services.

Hugh Gordon: — Any timeline as to when you'll be done? That could be quarterly, yearly.

Julia Pemberton: — We'll work with our Social Services partners to develop a timeline for reporting.

Hugh Gordon: — Okay, stay tuned. Thank you. That's all my questions.

Chair Wotherspoon: — Any further questions from committee members? Not seeing any, I'd welcome a motion to conclude consideration of chapter 27.

James Thorsteinson: — I'll so move.

Chair Wotherspoon: — Okay, moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We'll turn our attention to chapter 24, and I'll turn it back over to the Provincial Auditor and her office.

Jason Wandy: — Thank you. Hard-to-recruit health care positions include those jobs responsible for directly delivering health care services where the Saskatchewan Health Authority has trouble in recruiting and retaining staff with the required competencies for the role. Having staff shortages for a long period can contribute to work overload and staff burnout.

Chapter 24 of our 2025 report volume 2 describes the results of our first follow-up of management's actions on the seven recommendations we first made in 2022 regarding the Authority's processes to fill hard-to-recruit health care positions. By August 2025 the Authority fully implemented three recommendations.

We found the Authority implemented processes to determine whether student clinical placements and post-secondary training seats purchased out of province are successful recruitment strategies for hard-to-recruit positions. It hired almost 136 staff who completed clinical placements with the Authority and almost 80 per cent of graduated students from training seats purchased out of province in 2024.

Additionally the Authority established targets and reported on performance measures, such as the chronic vacancy rates, to evaluate the success of its recruitment and retention strategies for hard-to-recruit positions. We found the Authority made progress in reducing chronic vacancies in hard-to-recruit positions between June 2024 and 2025. It reported a reduction in the overall chronic vacancy rate from 4.9 per cent to 3.6 per cent.

The Authority partially implemented the two recommendations on page 235, where we recommended the Saskatchewan Health Authority determine in which facility locations across the province it expects to have the most significant shortages of hard-to-recruit positions, and implement targeted plans to address recruitment and retention for specific hard-to-recruit positions where it expects to have significant gaps.

The Authority maintains a vacancy dashboard to track various information about existing vacancies for hard-to-recruit positions across the province, including the occupation, location, and facility. While the dashboard provides the Authority with information about current staffing gaps for hard-to-recruit positions at specific facility locations, the Authority had yet to begin forecasting in which facility locations it expects to have the most significant shortages of hard-to-recruit positions.

For example, an analysis of expected staffing gaps by facility location across the province could provide the Authority with information to help proactively prioritize and tailor its recruitment processes accordingly, such as considering the need for community engagement or assessing the need for accessible housing in a community.

We found the Authority — on a pilot basis — forecasted future needs for certain hard-to-recruit positions for two significant capital projects under construction in La Ronge and Grenfell. For example, the Authority's work plan for the project in La Ronge included the need for four registered nurses and five licensed practical nurses. The Authority planned to fill these positions in 2025-26.

We also found the Authority has individual recruitment plans for positions it identifies as hard to recruit. Our testing of four plans for those chronically vacant positions found that plans did not include analysis of identified root causes to evaluate possible reasons for significant staffing gaps. Additionally we found the plans similar in nature and not unique.

Understanding where in the province it expects to experience the most significant shortages of hard-to-recruit positions, and why, can help the Authority toward developing more targeted recruitment and retention plans that address root causes, such as lack of housing or a need for financial incentives that may be unique to certain areas of the province.

Analyzing expected staffing gaps by facility location across the province can assist the Authority in determining where it needs staff most and help it implement appropriate and targeted plans. Doing so should help the Authority minimize service disruptions to the public by addressing positions with chronic vacancies.

The Authority partially implemented our recommendation on page 239, where we recommended the Saskatchewan Health Authority implement a First Nations and Métis recruitment and retention plan to help fill hard-to-recruit positions. The Authority set a First Nations and Métis recruitment and retention plan, highlighting key actions for increasing Indigenous representation within the Authority's workforce, along with performance measures to help assess whether its plan is successful.

[14:30]

However it had yet to develop targets for each performance measure, such as a target percentage of Indigenous staff working throughout the Authority's various regions across the province. Lack of targets for all performance measures limits the Authority's ability to assess whether their First Nations and Métis recruitment and retention plan successfully contributes toward a diverse workforce and ultimately helps to fill hard-to-recruit positions.

The Authority partially implemented our recommendation on page 240, where we recommended the Saskatchewan Health Authority centralize its analysis of staff exit surveys to inform retention strategies for hard-to-recruit positions. In January 2024 the Authority began using a service provider to centrally administer and collect staff exit surveys. We found the Authority shared the survey results with senior management at least annually. However we found the Authority has yet to analyze the results to inform any adjustments to its retention strategies for hard-to-recruit positions. Management expected to prioritize data analysis in fall 2025 to help inform their retention strategies.

Staff exit surveys can provide an organization with valuable information about where it can improve. Lack of analysis of staff exit surveys limits the Authority's ability to assess the effectiveness of and adjust its recruitment and retention efforts for hard-to-recruit positions.

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

Chair Wotherspoon: — Okay. Well thank you very much for the very important focus here in this presentation, the follow-up here, the recommendations that were brought to us in the 2022 report. I'll turn it over to ADM O'Neill for some brief remarks. Thanks for the actions that have been reflected in the status update. Then we'll go to the questions.

Norman O'Neill: — Okay. I'll just touch on the four outstanding recommendations, starting with recommendations 1, 2, then 5 and 6.

So regarding the recommendation for the SHA to determine which facility locations have the most significant shortages of positions, the SHA uses a provincial vacancy dashboard to monitor hard-to-recruit positions by occupation, facility location, and duration of vacancy. This provides operational visibility into current staffing pressures across the province.

The SHA performs provincial workforce forecasting to identify projected shortages in key hard-to-recruit classifications over a five-year period. While current tools identify existing vacancies and provincial workforce gaps, there is an opportunity to further enhance these capabilities by incorporating forecasting of shortages at the local geographic level.

Workforce planning and analytics teams are expanding

forecasting capabilities to model staffing needs by geography and community. Pilot work is currently under way at two sites with phased implementation planned for additional locations. Enhanced forecasting analysis is expected to support earlier identification of geographical staffing shortages and improve the SHA's ability to prioritize recruitment actions and retention supports based on local workforce risks and operational pressures.

The SHA incorporates workforce planning forecast requirements associated with upcoming capital projects and facility expansions, including the use of advanced hiring strategies to support timely recruitment and onboarding of staff required to safely operationalize new or expanded services.

Surrounding the recommendation for the SHA to implement targeted plans to address recruitment and retention, the SHA has implemented recruitment plans for hard-to-recruit classifications. This is supported by health human resources operational plans and aligned with the Government of Saskatchewan's health human resources action plan.

Recruitment and retention strategies currently in place include domestic and international recruitment, partnerships with post-secondary institutions, enhanced use of social media and recruitment campaigns, and targeted incentives for rural and remote communities. Strategies include expanding full-time positions in high-need areas, as well as employee wellness and retention initiatives to reduce turnover and improve workforce stability.

The SHA also continues to support recruitment and retention through a competitive total compensation approach that includes salary, paid time off, comprehensive health and dental benefits, pension, professional development opportunities, and additional recruitment and retention incentives for eligible positions and communities. The SHA works with the Saskatchewan Healthcare Recruitment Agency to enhance recruitment efforts locally, nationally, and internationally, improving access to qualified candidates for hard-to-fill positions.

Moving to recommendation 5, which is for the SHA to implement a First Nations and Métis recruitment and retention plan, the SHA has developed and implemented a plan which is aligned with the SHA health human resources operational plan for 2022 through 2026. The strategy is structured around four pillars which are recruitment, retention, incentives, and training, and includes initiatives such as partnerships with Indigenous post-secondary institutions, targeted recruitment strategies to attract Indigenous talent, and modernization of bursary and incentive programs to support Indigenous candidates.

The plan also supports Indigenous employees through initiatives such as Indigenous employee networks, improved mentorship and career advancement opportunities, and culturally appropriate supports — for example, access to elders and healers and Indigenous-specific cognitive behavioural therapy.

Work under way to further strengthen measurement frameworks and align targets with population, and work is under way to align these targets with population demographics and workforce needs. The SHA continues to advance implementation of the strategy in alignment with the Government of Saskatchewan, health human resources action plan, and internal workforce planning priorities.

A final recommendation I'll touch on is the one regarding the SHA to centralize its analysis of staff exit surveys. The SHA has centralized the collection of staff exit survey data through a third-party provider, with all exit survey information now consolidated at the corporate level.

A standardized exit survey tool and process has been implemented to support consistent and comparable data collection. All data collection has been centralized. The next step for the SHA is to complete a formal, structured analysis of exit survey results to identify key themes, root causes of turnover, or specific retention issues related to hard-to-recruit positions.

Exit survey results are periodically shared with SHA executive leadership to provide visibility into reasons for workforce turnover across the organization. The SHA plans to further analyze exit survey data to identify trends and support the development of evidence-based retention strategies for hard-to-recruit classifications.

And with that I'll complete my comments.

Chair Wotherspoon: — Thanks for the update, the actions that have been taken. I'll open it up now to committee members for questions. MLA Pratchler.

Joan Pratchler: — Just wondering, when did the work on the vacancy dashboard begin?

Mike Northcott: — That dashboard has been in place for a number of years. I believe it was around 2022, '23, but it's been in place for a number of years. If you need the exact date, I can bring that back to you.

Joan Pratchler: — Thank you, because the timeline for implementation says it's 2026.

Mike Northcott: — For the dashboard?

Joan Pratchler: — Yeah. Or am I misunderstanding that?

Mike Northcott: — No, the vacancy dashboard we've been using for a number of years.

Joan Pratchler: — Is it the geographical forecasting that is the part that we're looking at here?

Mike Northcott: — Yes, it is.

Joan Pratchler: — Okay.

Mike Northcott: — And do you want me to expand on that?

Joan Pratchler: — Yeah, if you could.

Mike Northcott: — Yeah. So the team has started to do some work around and started with the initial auditor recommendation around that facility level. We have found through that work that there is . . . It's hard to make predictions on facility level when you have smaller numbers. So for instance, if you have five

people in a classification, one person leaving can make a big difference there. But it's really difficult in that small of a sample size.

So you know, in consultation with the Provincial Auditor office, we've expanded that approach to be looking at more the geographic area so that you have a little bit more critical mass, so that you can make more accurate predictions and better manage that. So that's the piece that we're working on now with implementation target in 2026.

Joan Pratchler: — So this is providing the data to look, so they have a sense of what classifications you're actually looking for to fill. Is that correct?

Mike Northcott: — Yes, so we'd be looking at the hard-to-recruit classifications, and we'd be looking at factors like turnover, retirement rates, trends. So when we look at the overall analysis on a provincial level, and there's a number of factors that go into it, it's really bringing that into a local level but then also looking at, is there some more local factors that need to be considered.

Joan Pratchler: — So it seems to me that you're kind of just saying, these are the list of people that we need; we now know some of the reasons, but this is the list of people that we need to start recruiting.

Mike Northcott: — Yeah, so it's a matter of, you know, we've got our hard-to-recruit list, and understanding in the big picture, in the provincial picture, where we have those risks, where we're projecting gaps. So we'd look at how many graduates are coming out, how many people are exiting the system, and looking at . . . not an exact science, but it's a pretty robust tool. So basically moving that to more of the local geographic area to identify, okay, we've got some risks in this classification, so then what strategies do we use to address the risks that exist.

Joan Pratchler: — So this really isn't part of the recruitment and retention. This is just a precursor to the ambitious recruitment and retention plan.

Mike Northcott: — I think it's part of the recruitment and retention because it's looking at those factors. And so on the recruitment side of things, we can be proactive if we understand, hey, we've got a risk coming on this classification. And then on the retention side of things if we can, you know, when staff have to . . . Say there's a gap in staffing. If we can prevent that gap, then that creates a better work environment for those other staff that are working at that facility.

Joan Pratchler: — So you're already using some of this data that you're finding and implementing it already?

Mike Northcott: — Yeah, we've got it more on the provincial level and then in targeted areas. So for instance the capital builds that Norm referenced there, looking at that to do pre-hiring, so earlier hiring, so that we can ramp up to meet those needs.

Joan Pratchler: — Thank you. Do you have the ability to give us an interim report of geographically what kind of positions are hard to recruit for, based on geography?

Mike Northcott: — We have the hard-to-recruit list on a provincial level, so it's SHA-wide. But part of the analysis that I'm talking about with looking at more the geography-based analysis would then lead us to a better understanding of where we might have additional risks in certain classifications in those geographies. So I don't have a hard-to-recruit list per geography. We have an overall SHA.

Joan Pratchler: — So can you furnish an interim report of what are the hard-to-recruit positions?

Mike Northcott: — Yeah, I believe it's also in the auditor's report actually listed.

Joan Pratchler: — It wouldn't be currently? Or has a lot changed since then?

Mike Northcott: — Not a lot has changed since then. It's on our website, so I mean it's public, yeah.

Joan Pratchler: — In the report it says that 136 staff who completed clinical placements with the Authority, almost 80 per cent of graduated students from training seats purchased outside of the province came back to Saskatchewan. So 136 out of how many?

[14:45]

Mike Northcott: — I don't have that exact number with me. But if we kind of extrapolate, if we hired 80 per cent and extrapolate, it's about 170.

Joan Pratchler: — What happened to the other 20 per cent? Where did they go?

Mike Northcott: — Well individuals make life choices. And you know, if someone goes away to school in a different province, of course we want to hire them back and we engage with them regularly to make conditional job offers. But sometimes life circumstances happen and people make different choices as to where to live.

Joan Pratchler: — So 20 per cent is a pretty high number not to come back after we've paid to train them and they stayed in place X where they took their training. Is that what this is saying? Or they . . .

Mike Northcott: — Yes, basically we're saying that 80 per cent of them do come back — 20 make other life choices — and of course we want to see that number increase. We want to hire 100 per cent of people in those as well as all of our new grads in our programs.

Joan Pratchler: — And what would be the classification of those training seats? Are they occupational therapists? Are they resp [respiratory] therapists? What would they typically be when they have to go out of province for training?

Mike Northcott: — Yeah, those are good examples. Yeah, occupational therapists, audiologists, speech-language pathologists. It's just programs that we don't offer in Saskatchewan right now. And that's where I'm excited about some of the new course offerings in Saskatchewan now, with

OT [occupational therapy] as well as speech programs that are coming online as well as others as well.

Joan Pratchler: — So those are ones that are going to be offered here in Saskatchewan, which is great.

Mike Northcott: — That's correct.

Joan Pratchler: — Are those the only ones we sent out of the province for training?

Mike Northcott: — No, there would be more. I was just giving some examples.

Joan Pratchler: — And so what would be the examples? It certainly wouldn't be nursing or medical. I mean what would be some of the other ones?

Mike Northcott: — Perfusionist would be another example. So a lot of the technical training.

Joan Pratchler: — Lab techs?

Mike Northcott: — I don't think lab techs is on there.

Joan Pratchler: — Yeah, I just want to understand what are we sending them out of the province for that maybe we could be doing here?

Mike Northcott: — Okay, so I did go through my binder and I found the list. So radiation therapy, nuclear medicine technology, magnetic resonance imaging, environmental public health, diagnostic medical stenography, respiratory therapy, occupational therapy, speech-language pathology, electroneurophysiology, cardiovascular perfusion, prosthetics and orthotics, and cardiology technology. It's those technical, a lot of them. Yeah.

Joan Pratchler: — And so of course you know my next question's going to be, how much does it cost us in Saskatchewan to train health care workers from other provinces? And what would that bottom line number be?

Norman O'Neill: — In other provinces?

Joan Pratchler: — How much are we paying to get 80 per cent back?

Norman O'Neill: — Just for that question, it's not something that we know. So funding is provided through the Ministry of Advanced Education to the post-secondary institutions. It's not provided through the sector. So it would have to be answered by Advanced Education.

Chair Wotherspoon: — The auditor's got something to offer here too.

Tara Clemett: — Yeah, I'll just weigh in. And you'll notice on page 238 the footnote at the bottom of the page. So that is a 2025 number, but AE [Advanced Education] spent about just over 6 million.

Joan Pratchler: — Thank you.

Tara Clemett: — You're welcome.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — How exactly is the SHA now reporting on performance measures to evaluate the success of its recruitment and retention strategies for those hard-to-recruit positions?

Mike Northcott: — Okay, so our key measure here is our chronic vacancies. And so that's where . . . I'll just go through a few numbers. And I'm quite excited to share them because we've continued to make good progress. So our hard-to-recruit — this is permanent full-time and part-time chronic vacancies — reduced 42 per cent from March of 2023 to March 2026. So kind of the reduction in vacancy rate went from 5 in March of 2023 to 2.9 per cent in '26.

I would just pull out the nursing numbers too because we made a lot of good progress there. Overall we've seen a decrease of 55.6 per cent during that same time period, so going from 5.4 per cent to 2.4 per cent. And then we've seen even more drastic results in the rural and North where we've seen a 69.5 per cent reduction, going from 8.2 per cent to 2.5 per cent over that same period.

And you know, some things that have really, really helped in that regard are the incentives that are offered, as well as we've created new and enhanced positions to enhance staffing in those areas and really stabilize staffing, especially in those emergs in the rural and remote.

Hugh Gordon: — I guess follow-up to that, my question was like how are you reporting on those performance measures? Like you've got that information, but how are you reporting that?

Mike Northcott: — So we regularly report to the board. So our governance and human resources committee, we have a standing item every quarter that we report on health human resources initiatives and results. And this is generally the first one out of the gate in that report.

Hugh Gordon: — So you report that to the board?

Mike Northcott: — Yes.

Hugh Gordon: — This success, these measures, performance measures, how you're doing in these different areas, chronic vacancies in certain positions — might be nursing — but that all gets amalgamated, reported to the board? Do I understand that correctly?

Mike Northcott: — That's right.

Hugh Gordon: — Thank you.

Joan Pratchler: — Can I just do a follow-up question on the nursing part? Has any study been done as to the amount of nursing graduates that exit and convocate, as to how many are engaged and employed in the SHA organization itself? Like is there any drop-offs between convocation and direct deployment?

Mike Northcott: — Yes. So we work closely with Advanced Education around that, and typically we see in the 91 per cent range there.

Joan Pratchler: — Okay. And those are full-time positions?

Mike Northcott: — No, those aren't all full-time positions. Some nursing graduates come out and they don't necessarily want a full-time job, right. So we've been having efforts to create more full-time positions because it allows us to stabilize more and create that opportunity. But not everyone coming out of school or later in their career wants to work full-time, so we do have part-time positions as well.

Joan Pratchler: — Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — What are some of the community-specific barriers the SHA is encountering in recruitment, and how is the SHA addressing these barriers?

[15:00]

Mike Northcott: — Thank you for your question. So a number of strategies here and I guess challenges that I'll identify. So sometimes the remoteness of a community brings challenges where folks may not want to choose to live there, and so that's harder to recruit to those communities.

Examples in those and other spaces of things that we're doing is, you know, I'll go back to when we recruited the Philippines nurses. We created a housing registry, so kind of a matching service to understand from the community if there's housing available that they would be open to renting out, their basement suite or what have you. So that's an example of some of the things that, you know . . . finding solutions to those problems.

Partnering with the Saskatchewan Healthcare Recruitment Agency. So they're working closely with communities to understand what are those local barriers and how do we work together to address those.

I would also just highlight the remote incentives. So that has been a very effective tool in our tool box. And that, combined with the additional positions that I talked about, really has worked well together.

Overall, you know, there's a lot of competition in Canada for those hard-to-recruit positions. Take respiratory therapists as an example. There's a lot of competition for that, so we need to remain competitive in that.

And you know, other creative solutions, like if someone is coming in to work in a location, do they have a spouse? Does that spouse also have a health care background or is there a role for them? Because often, you know, if a family is moving, then that can be very helpful in helping to recruit and retain.

Oh I was just going to add too, not all the hard-to-recruit positions are in rural and remote. There's, you know, critical care nurses, for instance, or emerg nurses. And doing creative things. Like we've recently created both a critical care and an emergency video that involved the staff and really talking about what is it like to work in here, what's the team atmosphere, and creating that inviting atmosphere and encouraging colleagues to come and give ICU [intensive care unit] a try and we'll support you. Similar with emerg. And so we're finding that that's helping.

And there's no one solution to the challenges, so it's really understanding those drivers and then what can we do to address.

Joan Pratchler: — One of the things that we've been hearing during our consultations is that SHA doesn't always regularly perform exit interviews with senior SHA personnel leaving the organization. And of course we know that those have significant institutional knowledge. Was that consistent with your review?

Mike Northcott: — You said exit interviews, correct?

Joan Pratchler: — With senior . . .

Mike Northcott: — So folks are offered an exit interview. So we do the standard exit survey, but if someone wants an exit interview . . . We ask that question, and if they would like an exit interview we do an exit interview.

Joan Pratchler: — Okay. Is the SHA finding the First Nation and Métis recruitment and retention plan to be successful? If so, what would be your parameters or indicators of that?

Mike Northcott: — Yeah, so we're excited to have Jennifer Ahenakew come into our organization as the vice-president for that area. And she just brings a wealth of knowledge and excitement and energy to this work. And since implementing the plan, like we are seeing forward progress, but we have a long way to go as well.

And so we are seeing that forward progress, doing things like the Indigenous employee network. So Jennifer and I kicked that off, and it's really around creating a welcoming environment. It's about helping people feel that they belong in the SHA and have a community of support. And that's going to help retain, but it's also going to help recruit when they talk to their family or friends to say, hey, SHA really cares about this, having a representative workforce, and these are the things that they're doing and this is how I'm feeling about it, and come and join our team.

Joan Pratchler: — And when I look at the target that's sort of outlined here, the target was, you know, 15 per cent, and we're at 5.15. But now this is a bit older, right? Has that improved, do you think, into 2026?

Mike Northcott: — It's improved slightly. The last metric that I saw was 5.35, but that's when I go back to . . . We have a lot of work to do. That's . . .

Joan Pratchler: — And is it priority work?

Mike Northcott: — It is priority work, absolutely. Yeah.

Joan Pratchler: — Good. Who's the third-party provider centralizing the exit survey data?

Mike Northcott: — McLean & Company. They're a Canadian company.

Joan Pratchler: — And how often is that data shared with leadership?

Mike Northcott: — It's about twice a year.

Joan Pratchler: — Is that enough?

Mike Northcott: — Well we're fairly new into the cycle. So I take your point, and we can look at the frequency. And as we engage our senior leaders too, I think that's part of the question is how often and what's the most meaningful. Really it's about understanding those themes and aligning strategies accordingly.

Joan Pratchler: — So that initiative, is that simply urban or is it going to be provincially in the province as well?

Mike Northcott: — Yeah, it's provincial. It's provincial.

Joan Pratchler: — Okay.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Thank you. What are some of the key themes and root causes of turnover that you're seeing in those hard-to-recruit positions?

Mike Northcott: — Okay, I can give an overview of the reasons why we see people leaving and some of the strategies that we're using accordingly. So retirement is an obvious one, that we have people leaving for retirement. We also see some folks struggling with a change in direction of a work area and they may take on different approaches, so really trying to support with that changed leadership to help people with change. As you know, there's a natural change curve that people go through.

Supervisor factors we see, so it's really about developing our leaders and ensuring that that workplace is creating a great work environment. So examples there: manager orientation enhancements, manager training, leadership coaching, building effective teams, mentorship programs. And then also, you know, something that comes up sometimes is interdepartmental-type issues, and so again helping them with effective teamwork.

I would also just highlight paid compensation is a factor at times as well as culture factors. So addressing that is leadership essentials training; crucial conversations training, so how do we have those crucial conversations; building effective teams again; our belonging, diversity, and inclusion work to make sure that everyone's feeling like they belong to the team; our anti-racism training and Indigenous employee network that I spoke about earlier.

And we've also got a recognition tool kit to identify ways of how can you recognize people best, and just ideas, right. So I'd pause there.

Hugh Gordon: — Where are the performance measures such as vacancy trends, recruitment outcomes, staffing levels by classification and location reported? Is this report going to be publicly available?

[15:15]

Mike Northcott: — Okay, so the detailed aspects of that are tracked internally. And we work closely with the ministry around that, so my team as well as the ministry team on the more detailed reports. As I indicated before, we report the vacancy rates to the board committee on a quarterly basis. And then I would also highlight that in the public portion of the board meeting, Andrew speaks to those high-level numbers that I gave as well in the public portion.

Joan Pratchler: — Would you be able to tell me like general trends over the past four years of what your vacancy trends are, what your recruitment outcomes have been, and what your staffing levels by classification and location have been, and retention rates once they've been recruited? Or furnish them to the committee if that takes like far too long to do right now.

Mike Northcott: — Can you repeat that question. Sorry.

Joan Pratchler: — Sure. Over the past four years: vacancy trends, recruitment outcomes, staffing levels by classification and location — and I'm thinking regionally if we could go back to the different regions — and the last one, retention rates once new people have been recruited in these past four. I think four years would be what we could use.

Mike Northcott: — Okay, so what you've asked for would be a major undertaking. What we can do is go back and we'd look at the nine classifications that are under the rural and remote incentives and provide you with recruitment trends there.

In terms of the vacancy trends, I'd kind of go back to the numbers that I shared earlier. That was the last three years. I know you'd asked for four years, but that trend is definitely improving and we're seeing significant gains there, which we're very happy about. And there's more work to do in that space because even if we're, you know, around that 2 per cent vacancy, there's still vacancies there that we want to fill in order to serve patients. Yeah, I'll leave it at that.

Joan Pratchler: — And the retention rates once recruited?

Mike Northcott: — Yeah, we've seen generally fairly stable retention rates actually.

Joan Pratchler: — Percentage, like 90? 80?

Mike Northcott: — Give me a second. So I think what we can do is with those nine classifications we can also just build in that retention component with people fulfilling their obligations there.

Joan Pratchler: — Thank you. And you'll just send that to the committee along with the other things?

Mike Northcott: — If that works for the committee, we can.

Joan Pratchler: — Okay, thanks.

Chair Wotherspoon: — Just sort of, yeah, standard process. That sounds wonderful. Thanks for confirming that you'll supply that information and the Clerk will make sure you have the path to get that to the committee. Thank you very much.

Norman O'Neill: — We'll just follow the same timeline then as our other deliverables. Okay.

Chair Wotherspoon: — That's right. So far it sounds like everything's a 30-day window, so you can send it all at once or as it's available.

Norman O'Neill: — Yeah, we might have one 60-day, don't we?

Chair Wotherspoon: — We're going to shorten that timeline. No, that sounds great. Thank you.

Any further questions, committee members? Good questions and substantive exchange. Thanks to the officials for all their work, their teams, on this front as well. Not seeing any further questions on this chapter, I'd welcome a motion to conclude consideration of chapter 24.

James Thorsteinson: — So moved.

Chair Wotherspoon: — Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. We'll move right along to our last consideration of the day, that being chapter 25. And I'll turn it over to the Provincial Auditor and her office.

Jason Wandy: — Thank you, Mr. Chair. Managing employee absenteeism is a key aspect to controlling the costs of delivering health care in Saskatchewan and supports employee well-being.

Chapter 25 of our 2025 report volume 2 describes our third follow-up audit of management's actions on the three remaining recommendations we first made in 2017 regarding the Saskatchewan Health Authority's processes for minimizing employee absenteeism in Kindersley and surrounding areas.

By April 2025 the Authority continued to work on the three outstanding recommendations. In 2024-25 the Authority experienced higher sick time per employee than in 2018-19 by 23 per cent. The Authority partially implemented the recommendation on page 244 where we recommended the Saskatchewan Health Authority monitor that those responsible for employee attendance management document discussions and actions with employees who have excessive absenteeism.

In August 2023 the Authority established a new threshold for managers to identify and monitor employees with excessive absenteeism, that being when an employee's sick hours exceed 10 per cent of their scheduled hours. Between April 2024 and March 2025 we found about 25 per cent of the Authority's employees in Kindersley and surrounding areas had sick leave exceeding the target threshold.

We found the Authority provides managers with ad hoc reports — that is attendance reports or calendars — to monitor employees with excessive absenteeism. It expects managers to meet with employees with excessive absenteeism and document their discussions in a checklist. We tested five employees' records with excessive absenteeism and found no evidence of managers monitoring or documenting discussions about excessive absenteeism.

The Authority planned to implement a new attendance support program in 2026 that provides managers with tools to identify potential attendance concerns and address absenteeism, along with setting out documentation requirements for progressing employees with excessive absenteeism through the program.

Additionally, the Authority indicated it was working toward implementing a process in 2026 for an IT ticketing system to help managers track and document actions for addressing employees with excessive absenteeism. Without proper records, managers cannot demonstrate how or whether they determine the reasons for identified absences of employees with excessive absenteeism. Doing so can assist in understanding significant causes for employee absenteeism.

The Authority partially implemented the two recommendations on pages 245 and 246 where we recommended the Saskatchewan Health Authority analyze significant causes of its employees' absenteeism and implement targeted strategies to address them, and give the board periodic reports on the progress of attendance management strategies in reducing employee absenteeism and related costs.

The Authority manually collects data on reasons for employee absenteeism when managers meet with employees. However as previously described, these meetings are not always held and therefore absenteeism data collected by the Authority may not be sufficiently complete. Authority management uses this data to produce annual summary reports about the primary causes for absenteeism for the board's human resources and governance committee.

In the rural areas, which includes Kindersley and surrounding areas, employees cited physical health as the most common reason for absenteeism. Since 2023, the Authority continues to offer educational resources and information packages to employees, but has not monitored whether these resources successfully reduce employee absenteeism or whether it requires additional targeted strategies.

We assessed the reports provided to the board's human resources and governance committee in September 2023 and 2024. We found the reports contained details about the main causes of absenteeism but did not discuss trends or patterns or targets, nor did the reports convey strategies the Authority is taking to reduce employee absenteeism.

Collecting and analyzing necessary data on causes of absenteeism would assist in developing and evaluating attendance management strategies to reduce excessive employee absenteeism. Reporting that includes reliable data assessing key causes and strategies would help the board understand whether the Authority is effectively reducing employee absenteeism and whether additional changes and strategies are necessary.

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

Chair Wotherspoon: — Thanks for the focus and the follow-up on this front. I'll turn it over to ADM O'Neill for a brief remark and then we'll kick it open for questions.

Norman O'Neill: — Thank you. So regarding the recommendation for the SHA to monitor those responsible for employee attendance management, to document discussions and

actions, the SHA has implemented the attendance support program.

[15:30]

This includes attendance records, calendars, and structured discussion checklists to guide managers in addressing excessive absenteeism. Managers are expected to meet with employees who have excessive absenteeism and document contributing factors, supports, and action plans.

The SHA has issued a request for proposals for a vendor to provide attendance and return-to-work services. The service model will introduce centralized end-to-end case management, a responsibility for documentation, communication, medical follow-up, and return-to-work planning is coordinated through a standardized approach. The service sought through the request for proposals includes documentation of discussions and actions with employees who have excessive absenteeism.

Surrounding the recommendation for the SHA to analyze significant causes of its employees' absenteeism and implement strategies, the SHA continues to collect absenteeism information. The SHA collects absenteeism data through attendance discussions and reporting processes, identifying mental health, physical health, family-related responsibilities, chronic disease, and addictions and substance abuse as primary drivers.

When an external service is procured and onboarded, improvements to data quality and analytical capability will occur through the standardization of data collection and absence information across the organization. This will enable more reliable identification of trends and root causes, including by location and employee group.

Planned analytics enhancements will support targeted early intervention and prevention strategies, improve employee wellness outcomes, and contribute to reduced absence duration and improved continuity of care.

Concerning the recommendation for the SHA to give the board periodic reports on the progress of attendance management strategies, the SHA currently provides summary reporting on absenteeism trends and key drivers to the board's human resources and governance committee.

Through the implementation of the vendor-supported model, SHA will introduce performance-based reporting with defined metrics. Enhanced reporting will include regular updates on attendance trends, drivers, and progress on attendance management strategies. This will strengthen governance oversight, improve transparency, and support evidence-based decision making, including demonstrating return on investment through measurable reductions in absenteeism-related costs.

That concludes my comments.

Chair Wotherspoon: — Okay. Thank you. I'll open it up now to committee members that may have questions. MLA Gordon.

Hugh Gordon: — Thank you. Can you share with the committee today if the pilot for the integrated vendor-supported case management and documentation system has begun? And if it has, does it still remain on track for full implementation by end of this year?

Mike Northcott: — So we are in the final stages working towards awarding that contract. So that pilot that you referenced has not started yet because the contract isn't signed off. But we're planning to have that pilot begin over the summer.

Hugh Gordon: — And can you just share with the committee, like what do you mean by vendor-supported case management and documentation? What does that entail? What does that look like for you?

Mike Northcott: — Yeah, so we're looking for a vendor that has that infrastructure to then be . . . So they'd be dealing with the cases, but they'd also have the infrastructure where they'd be documenting those conversations and processes.

Hugh Gordon: — Thank you. Takes care of my question number three.

Chair Wotherspoon: — MLA Pratchler.

Joan Pratchler: — Thanks. So does that mean that the managers aren't involved in this? Is this an outsourcing of absenteeism management? Or maybe I'm missing something.

Mike Northcott: — We're working through the details of exactly who does what, but at the end of the day, we do want to reduce the administrative pieces on the managers. But the managers are still the employees' managers, so they have a role in this. So we're just working through the details of exactly where that interplay and hand-off . . . and I shouldn't say hand-off, but the roles and responsibilities within that. We're just working through the detail on that.

Joan Pratchler: — And you've already set up how you might evaluate that periodically as it goes through? Is it just a pilot now? Or how do you know if it's going to work?

Mike Northcott: — Yeah, I would more frame it around . . . We would do a first implementation with a smaller geographic area, and then we would evaluate it. So that's part of what we're doing now is around what are those key performance indicators to measure success. And then as with anything, I think we're going to see lessons learned and what can we improve upon that for the next implementation as we go through the province.

Joan Pratchler: — So the vendors that you're reviewing would already have some of those performance indicators in mind? Or we're going to make . . .

Mike Northcott: — Yeah, so it's a bit of back-and-forth, right?

Joan Pratchler: — Okay.

Mike Northcott: — Because the vendors, they do this as a business. So they have key performance indicators, so they would share those with us. And then we're looking at it to say, okay, are there any missing that we feel are important? So it's a little bit of back-and-forth on that.

Joan Pratchler: — And you're still looking for that one vendor?

You're still sorting through a variety of vendors?

Mike Northcott: — So we have had a number of vendors come forward with proposals. We are in the final stages of that process. And just given the procurement rules, I just want to be respectful of not saying anything out of turn within the procurement process.

Joan Pratchler: — Thank you. So in '24-25 the SHA spent $234 million province-wide on employee overtime, including 74 million in Kindersley and surrounding area. That's a quarter of all the overtime spent in the entire province. Are you able to track what would be other large outlays of overtime paid by region? So if Kindersley spent one-third of it, the other two-thirds, how would we account for that, just in rough packages?

Norman O'Neill: — Can you help us find where you're seeing the reference?

Joan Pratchler: — I'm sorry. Can you say that again?

Norman O'Neill: — Can you help us find where you're seeing the reference in the report that you're talking about the 75?

Joan Pratchler: — 74 million in Kindersley?

Norman O'Neill: — 74 million? Yeah.

Joan Pratchler: — Yeah, I assume it was in here. I just wrote it down. I'd have to look at what page that was, but 234 million province-wide.

Norman O'Neill: — That's probably more within what we would expect. But the 74 within Kindersley, it seems very high to us.

Joan Pratchler: — Let's see. Two . . . 244.

Norman O'Neill: — Okay, we found it. Thank you.

Joan Pratchler: — You did? Okay, thanks.

Mike Northcott: — Okay, so the 74 million, we've given that some thought, and you probably read it on our faces that it didn't seem quite right coming out of the gates. Just the context is the former Heartland would've had about 1,000 employees. So the 74 million in that context doesn't quite jive, yeah.

Tara Clemett: — And that number is our number, so I would be the one who would have to . . . We would have source documentation to figure out where we got that from. And I probably have to circulate it potentially back to them, to then . . . They'd have to understand what that . . . But I agree. That number seems . . .

A Member: — It does seem odd, right?

Mike Northcott: — Yeah.

Tara Clemett: — Yeah, just based on our . . . It seems high because . . . Yeah. And we think about even, like . . . or just . . .

Andrew Will: — I'm on my way right after this.

Tara Clemett: — Okay.

Mike Northcott: — But I can give more context around overtime. So we have created a dashboard using the AIMS system. So basically it goes right from the high level. So there's an overall SHA report that shows, okay, here's the overtime used; here's what was used previously. And then it drills into each portfolio.

[15:45]

So for myself, I can either see at the overall organization level, I can see at my department level, or I can see other portfolios and drill right down. So we're using that so that leaders can make great decisions every day and really have that visible. And really where we see those high areas of overtime, doing wraparound support to understand what is the root cause of that and how do we problem solve to address that root cause.

Joan Pratchler: — So however that flow through works — let's just say it's 74 million — would you be able to explain why that happened, and then talk about what the other large . . . There's always going to be overtime. I'm not questioning that at all. But when a third of it is in one place, is another third in another place? So when that all comes back, can you just flesh that out so we, you know, can sleep at night?

Mike Northcott: — So overtime is a focus for us this year. And we know that it puts a burden on staff when they have to work more hours and also impacts patient care if staff are, you know, extended. So when I look at the numbers — and going back to your question around is there other pockets — given this focus that we've had on overtime, I've looked across. So I can't recite all the numbers to you, but what I can say is that overtime is spread right throughout the geographies. There isn't a cluster.

Of course there's higher areas than others. But that's where — as I said before, identifying those higher numbers and doing that wraparound support — as we get further down the road with that analysis, we'll have more of those root causes that we'd be able to share, you know, further down the road at subsequent discussions. So that's the context on that.

Joan Pratchler: — And there's one more that may well relate to that is that, now that you're able to procure people to be in vacancies and that vacancy rate is being reduced, do you see yourself reducing the amount of travel nurses' contracts as well, now that you can get more stable nursing?

Mike Northcott: — So we have seen significant decreases in the utilization of contract nurses over the past few years, so approximately 30 per cent or more each of the past number of years.

A next step on that for us is really looking at that relationship. We've seen the contract nursing really come down. Our overtime keeps increasing and we want to see that decrease, so we really need to look at that relationship. And as you said, you know, sometimes overtime is going to happen. So it is a matter of ensuring that we have the staff there for patient care to provide the care, right, but really understanding what those drivers are.

And you're right. As we've seen those vacancy rates come down,

we're expecting . . . And that's a big driver of the reduction of contract nurses, right, especially with the Philippines recruitment and the incentives. But as we go forward, we need to monitor both that usage as well as the overtime.

Joan Pratchler: — Has someone . . . Perhaps you have. What is the impact or the inter-relationalities between the contract nurses or the impact of contract on your regular nursing staff? Has somebody researched that or are they in the process of researching? Because there's something going on there that's interesting, I would think.

Mike Northcott: — Yeah, we have further work to do on a deep dive on that.

Joan Pratchler: — Okay. And that will be a report, or how do you see that ending?

Mike Northcott: — There will be an analysis. I'm not sure what form that will take, but there will be an analysis on that.

Joan Pratchler: — Okay.

Tara Clemett: — So I will just mention that our office did complete an audit with regards to travel nurses, and that will be released at the end of June.

Joan Pratchler: — Okay, good. Thank you.

Chair Wotherspoon: — MLA Gordon.

Hugh Gordon: — Sure, maybe follow up on rates of overtime if you could discuss what those look like in the Kindersley area. We know they've got an absenteeism rate of 25 per cent. Just wondering if you could make a comment on the rate of overtime in that area.

And then what are the strategies you've identified to reduce the use of overtime and absenteeism? You know, we have heard that you're phasing out contract nurses and maybe cracking down on overtime and you want to see a more healthier balance. Perhaps you could insight us on that.

Andrew Will: — So I might share — just again thank you for that question — a few kind of overarching comments on the overtime piece, and then maybe turn it over to Mike to speak more about locally what are we doing to support management of overtime.

And I would just say certainly one of the things that's very important is that we have continuity of care, that we don't have interruptions in services. That's a priority for us. In health care we definitely see fluctuations in terms of the volumes of patients that have come to hospitals, etc. So sometimes overtime is necessary to be able to ensure the care that patients need.

So you know, I think at the end of the day we want to see our managers making really good decisions about when is it appropriate that overtime is used. As Mike said earlier, we also know that overtime takes a toll on people and sometimes the hours can be excessive, and that can create risks and safety issues and retention issues for people as well. So we're very mindful of overtime.

We made a comment a moment or so ago just in terms of, okay, in those exceptional circumstances where we need to have additional staffing and have that filled, finding the right balance between, you know, when do we contract staff and when do we authorize overtime. Those are things that we need to really dig into and understand.

I will say there's so many things right now that I expect will help us address some of the overtime challenges. Certainly the improvement we've seen in reducing vacancies in the system should have a very significant impact for us. We spoke moments ago about the attendance management return-to-work program and the contract that we're going to be putting into place. I think that also will have a very positive impact on, you know, having staff healthy and at work and providing care.

In rural areas one of the initiatives that we did over the past couple years is some supernumerary staffing, where we've increased above the baseline staffing so that if we do have an absence, we're not, you know, kind of immediately in trouble where we're into an overtime situation. And we've seen that has helped us even in terms of retention of staff in those facilities.

So there's lots of things under way, but we're still — and we'll acknowledge — we're still seeing overtime as a challenge for us. This will be a priority as we head into this year. Mike will speak a little bit. We're putting some processes in place for managers to make overtime more visible at every level of the organization, including at the manager level. We will be encouraging all of those leaders to really dig in and understand what is the root cause. Is it because of patient volume and load? Is it because of an unexpected absence that caused a challenge?

So I expect that, you know, every situation is going to be a little bit different. And then we'll support our leaders to really work on whatever the root cause is that relates to their unit or the service that they're delivering.

So as I mentioned, this will be one of our key focuses as the Saskatchewan Health Authority as we head through this year, and we've developed some processes to be able to support our leaders to do that.

Mike, anything that you would add to that?

Mike Northcott: — Yeah. Just a little more detail in terms of the processes that we've put in place to support. And I would just highlight the improvement huddle. So this is where we've identified the top areas in each portfolio, and then we have what we call an improvement huddle where basically we're bringing that data to the table. We're bringing the operational leaders. We're bringing quality improvement, finance, and human resources around that table to dive into, okay, what's really going on here to get to those root causes? And then collectively, okay, what can we do to address those root causes, to address the issue?

Joan Pratchler: — And so do you have a way of evaluating that or kind of following that? Like I assume this is a process that's going to continue for a fair amount of time to be able to see it through. What are you looking at for evaluating or reporting back progress?

Mike Northcott: — Yeah. It's ultimately, what's the overtime

utilization? That's our key metric in this space, and that goes back to the dashboard that I referenced earlier. So we want to see that curve, the direction go the other way, right? We want to see a decrease. And so you want to see that at not only the overall, but each individual right down to the individual unit level, right?

Joan Pratchler: — Yeah. That makes sense. That's all I have.

Chair Wotherspoon: — MLA Gordon? Any further questions from committee members? Not seeing any, I would welcome a motion to conclude consideration of chapter 25 at this time.

James Thorsteinson: — I so move.

Chair Wotherspoon: — Moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — Okay. That's carried. So that concludes the chapters that we have before us here today. I just want to thank ADM O'Neill, CEO Will, all the leadership that have joined us here today, the many others that have connected to this work and contributed to the work that's been discussed. Of course I thank the auditor and her team as well. But to ADM O'Neill, any final parting words before we kick you out of here?

Norman O'Neill: — Happy to be kicked out, but I'll also just thank the Provincial Auditor for the work that they've done and our positive working relationship. I'll thank the committee for their thoughtful questions. And of course I'll thank the officials as well who provided the answers today. Thanks again.

Chair Wotherspoon: — Excellent. Well thank you very much. I guess there's one last item I'd like to address here today, and that's the fact that we have someone at our table that's been with us and contributing in a really meaningful way for a long time that won't be with us again into the future. And Jane Borland, assistant provincial comptroller, is going to be retiring.

[16:00]

So I know I've chatted a little bit with our Provincial Comptroller, and just a few highlights here. Jane has served her province exceptionally well for 38 years with the Government of Saskatchewan, and she's made incredibly valuable contributions. And those have included, she's helped strengthen the preparation of the public accounts, ensuring the high-quality public statements and timeliness of reporting. During periods of change, Jane provided guidance and supported the transition to GEM [government enterprise management], the adoption of accrual accounting, and the rewrite of *The Financial Administration Act*. She's also provided exceptional leadership in financial reporting, accounting policy, and public-sector accounting.

Now I understand that Jane loves to travel. I believe she's travelled to over 50 countries around the world, which is just awesome, and plans to travel extensively into retirement. So to Jane Borland, on behalf of the Public Accounts Committee and I know a grateful province, we simply want to express our thanks to you for your remarkable career and your service to your province. And we want to wish you nothing but the best and many adventures in your retirement.

Jane Borland: — Thank you.

Chair Wotherspoon: — Okay, folks. Oh yeah, we can . . . I think we should give her a standing ovation. Thank you very much, Jane.

[Applause]

Jane Borland: — Thank you.

Chair Wotherspoon: — Am I missing anything else? All right, well I'd welcome a motion of adjournment at this time. It's always the most popular motion. Yeah, moved by Deputy Chair Thorsteinson. All agreed?

Some Hon. Members: — Agreed.

Chair Wotherspoon: — That's carried. This committee stands adjourned until the call of the Chair.

[The committee adjourned at 16:02.]