# STANDING COMMITTEE ON PUBLIC ACCOUNTS

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**STANDING COMMITTEE ON PUBLIC ACCOUNTS**

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Mr. Jim Lemaigre
Athabasca

Ms. Aleana Young
Regina University

[The committee met at 09:01.]

**The Chair**: — Well good morning, everyone. We'll convene the Standing Committee on Public Accounts. I'll introduce members of the committee that are with us here today: Deputy Chair, Mr. Hugh Nerlien; Mr. Todd Goudy; Ms. Lisa Lambert; Mr. Muhammad Fiaz is substituting for Mr. Jim Lemaigre today; Mr. Delbert Kirsch; Mr. Daryl Harrison; and Ms. Aleana Young.

I'd like to introduce our officials with the Provincial Comptroller's office that are with us today: Jane Borland, assistant provincial comptroller; and Tamara Stocker, director.

I'd like to welcome and introduce our Provincial Auditor, Tara Clemett, and her officials that are with us here today, thank them for all their work. And we'll turn our attention to Health I think for the entire day here today. So thank you so much to Deputy Minister Smith and all the officials from the various organizations that have joined us here today.

Deputy Minister Smith, would you care to briefly introduce the officials that are with you here today. You can refrain from getting into the respective chapters that the auditor is focused on. I'll turn it back to her after that, then come back your way.

## eHealth Saskatchewan

**Ms. Smith**: — Thank you, Mr. Chair. And good morning, everyone, and again thank you for the introductions. We are happy to be back here again today to discuss some of the chapters from the Provincial Auditor's reports. And I have with me some of the members from the team at the Ministry of Health.

But maybe I will just jump in to introducing the staff who are here today from eHealth, which is one of the chapters that we are going to discuss at the front end, and then I will wait to do some introductions for latter parts of today.

So to my right I've got Davin Church who is the CEO [chief executive officer] of eHealth Saskatchewan, and we have joining him John Billington who is the vice-president of corporate services and the CFO [chief financial officer]. And we have Lillian Ly who is the executive director of programs and the chief digital information officer joining us this morning.

And with that, again we are looking forward to the conversation today and some of the questions and just thank you again for this opportunity.

**The Chair**: — Thank you very much, Deputy Minister. I'll turn it over to the Provincial Auditor and I believe she's going to focus on chapter 1.

**Ms. Clemett**: — So thank you, Mr. Chair, Deputy Chair, members, and officials. With me today is Mr. Jason Wandy. He's the deputy provincial auditor of the Health division and he's responsible for the audits at eHealth Saskatchewan. Behind us as well is Ms. Michelle Lindenbach and she is our liaison with this committee.

This morning Jason's going to present the chapters for eHealth in the order they appear in the agenda. That will result in two presentations because we are going to combine the first two chapters together into one presentation. These presentations do not include any new recommendations for the committee's consideration.

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

**Mr. Wandy**: — Thank you, Tara. Chapter 1 of our 2022 report volume 2 and chapter 1 of our 2023 report volume 2 report the results of our annual integrated audit of eHealth Saskatchewan for the years ending March 31st, 2022 and March 31st, 2023. These chapters include updates on the status of four outstanding recommendations.

For the 2022 and 2023 fiscal years, we found eHealth's financial statements were reliable and it complied with the authorities governing its activities related to financial reporting and safeguarding public resources. Additionally eHealth had effective rules and procedures to safeguard public resources except for the areas highlighted in our four recommendations.

We found eHealth Saskatchewan partially implemented the recommendation on page 15 of both our 2022 report volume 2 and 2023 report volume 2, where we recommended eHealth Saskatchewan sign an adequate service level agreement with the Saskatchewan Health Authority. eHealth and the Saskatchewan Health Authority signed a new master services agreement in May 2022.

However at March 2023, they had yet to finalize key aspects of the agreement. Such aspects include disaster recovery, service levels, security requirements, and IT [information technology] change management. The Authority depends on its IT data and systems to deliver health care services to the public. Not having an adequate service level agreement increases the risk that eHealth fails to meet the Authority's IT needs. This could in turn increase the likelihood the Authority's systems are breached or unavailable for long periods of time.

We found eHealth Saskatchewan partially implemented the next recommendation on page 16 of both our 2022 report volume 2 and 2023 report volume 2 where we recommend eHealth Saskatchewan have an approved and tested disaster recovery plan for systems and data. eHealth is responsible for 35 critical IT systems. These are critical for the delivery of health care in the province. Critical IT systems include patient health information related to diagnostic imaging, drug prescriptions, laboratory results, hospital admissions, and public health records.

At March 2023 we found eHealth had disaster recovery playbooks for each of these critical systems but had yet to fully complete disaster recovery testing for these systems. We expect such testing to include periodic full restorations of the systems from backups. Testing recovery plans ensures that eHealth can restore critical IT systems in a reasonable time if a disaster occurs. This is especially important in the health sector where an IT failure can endanger patient health.

Pages 17 and 18 of our 2023 report volume 2 also include an update regarding two recommendations about eHealth's IT

network we first made in our 2019 audit of eHealth's processes for securing portable computing devices. We assess eHealth's progress to implement these recommendations annually. We recommended eHealth Saskatchewan implement a risk-based plan for controlling network access to mitigate the impact of security breaches. We also recommended eHealth Saskatchewan utilize key network security logs and scans to effectively monitor the eHealth IT network and detect malicious activity.

At March 2023 we found eHealth partially implemented both of these recommendations. They continue to make progress toward implementing effective network access controls and improved monitoring of the eHealth IT network. eHealth is working toward having centralized network access controls for all health sector agencies and network access ports. Network access control's primary function is to deny access to unauthorized devices or users while allowing authorized devices and users appropriate access.

eHealth is also working toward establishing relationships with service providers to help manage and monitor the security aspects of the eHealth IT network on a 24-7 basis. Effective network access controls and monitoring helps in preventing and detecting malicious activity timely, such as a successful attack on its network.

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

**The Chair**: — Thank you very much, and thank you for the focus of your work. I'll turn it over to Deputy Minister Smith for brief comments, then we'll open it up for questions.

**Ms. Smith**: — Thank you, Mr. Chair. So I think for the purposes of today I will sort of start with an initial response to the recommendations that were discussed and then will probably be turning to some of my colleagues who are here with us today.

So just with respect to the Provincial Auditor's recommendation surrounding implementing an annual security awareness training program, that was completed in their 2022 volume 2 report. eHealth introduced security awareness training for all employees in 2020. eHealth also consulted with health partner organizations to introduce the same security awareness training program. The Saskatchewan Health Authority is fully engaged and has committed to employee participation.

Surrounding the written plan to protect laptops in 2022, eHealth introduced an access management policy and a network access policy. As of late 2023, all supported end-user devices have been standardized, which includes security-focused configuration and modern security tools including device encryption.

Just give me one moment. I just want to ensure that we're doing the right chapters here. Okay. Apologies for that. I just want to make sure that . . . I was feeling like I'd missed the first recommendation that you had spoke to.

So just going back to one of the initial recommendations around the service level agreement, the information technology service level agreement version 1 was executed in May of 2022. eHealth and the Saskatchewan Health Authority are targeting to execute an agreement in the spring of 2024 and is leveraging the partnership committee to identify areas requiring attention, including those schedules outlined in the auditor's report.

eHealth and the Saskatchewan Health Authority jointly engaged with MLT in '23-24 to assist with the implementation of version 2 of the information technology service agreement.

Regarding the disaster recovery plan recommendation, eHealth has initiated the establishment of a disaster recovery program. The development phase has been started on a central repository, with the groundwork being laid out for a comprehensive and accessible hub for our recovery plans. eHealth is in the initial stages of developing performance metrics that will provide valuable insights into the effectiveness of the disaster recovery efforts. All eHealth-managed services are expected to have a disaster recovery playbook and subsequent tests approved and completed by March 31st of 2024.

And I think I've covered them now. Thank you.

**The Chair**: — Great. Thank you very much. I'll open it up now for questions. And I guess before I do that I'll just table the document PAC 136-29, Ministry of Health: Status update, dated February 26th, 2024. Thanks to all the folks involved in Health that completed that update for us. I'll open it up now for questions. Ms. Young.

**Ms. A. Young**: — Good morning. In the 2022 report, the final version of the master service agreement between eHealth and the SHA [Saskatchewan Health Authority] was expected to be completed by March 31, 2023. And I know you've referenced it in your opening comments, but can you expand on the reasons for the delay in executing this agreement?

[09:15]

**Ms. Smith**: — Thank you. I'm going to turn to Davin, who will introduce himself, to answer your question.

**Mr. Church**: — Good morning. Thank you. Davin Church, CEO, eHealth Saskatchewan. Thank you for the question. This is a priority for eHealth Saskatchewan and the Saskatchewan Health Authority. Certainly we want to put an agreement in place that has longevity and is effective for both of our organizations, which requires a lot of collaboration across both our organization and theirs.

And so we have done a lot of work just around the service-specific agreements, which lays out by service the service levels which are in review across our organizations now. However just with the amount of collaboration and time to review those and ensure that they are something that can be effective for both of our organizations and have longevity, we did want to and we are taking the time to ensure that those are appropriate and can be met by our organizations.

**Ms. A. Young**: — Thank you. And work on this agreement first began in . . . was it 2017?

**Mr. Church**: — Thank you for your question. Davin Church, CEO. So when the consolidation mandate came down in 2017, the SHA and eHealth Saskatchewan developed what was termed an interim operating agreement which we were operating under that agreement for a period of time.

In 2021 following a redirect of priorities between kind of 2019 and 2021, we got back to the focus around the ITSA, the IT service agreement between EHS [eHealth Saskatchewan] and SHA. And at that point we engaged MLT Aikins to support us in the development of the version 1 which we executed in May 2022.

So as far as the actual direct efforts into the IT service agreement as it stands today, those efforts really began in 2021 following the use of the interim operating agreement.

**Ms. A. Young**: — And seeing that spring 2024 is now identified as the target date for completion, are you confident that can be achieved?

**Mr. Church**: — Thanks for the question. By spring of 2024 we'll have a revised executed version of the IT service agreement, which will show progress in each one of those schedules, as outlined within the auditor's report. We will continue to add further details to those schedules as we continue our conversations and collaboration with the SHA.

I think it's important to note also there'll be continuous kind of annual reviews of the agreement. As new services are added or as different services are required, we'll continue to revise this agreement on a regular basis. So it will be somewhat of a living document. What we execute in the spring will not be a final version, but it will show progress in all of the areas identified by the Provincial Auditor.

**Ms. A. Young**: — Thank you. So help a lady understand: is the agreement ever to be executed or is it both always in a state of being executed and revised?

**Mr. Church**: — So we have an executed version now and as we make progress and as we make further changes to that, we will execute a revised version or an enhanced version each time.

**Ms. A. Young**: — Thank you. So just to be clear, the master service agreement between eHealth and SHA will be constantly under revision. It's an ongoing iterative process. Or is there an end date?

**Mr. Church**: — There are effective dates obviously within the agreement. Just as we make revisions or as we add new schedules — and that's really what we're focused on right now is not the legal framework of the document; it's the appended schedules of the document that form the more specific details of service-specific agreements and so forth — that we're amending and updating as we progress and as things change. Then we will make revisions to that and re-execute the document. But there are definitive end dates within the agreement as it stands in the current version.

**Ms. A. Young**: — Okay. Thank you. And those definitive end dates would vary based on the service that they're speaking to? Forgive me, maybe these are . . . I'm obviously not an expert in agreements of this scope. Is this standard, that agreements just continue to roll forward?

**Ms. Clemett**: — I don't know. I would ask, I guess, eHealth Saskatchewan. I can't recall if there's an expiry date. I guess from the auditor's perspective and our assessment, the adequacy of the agreement and this lack of schedules that eHealth is describing is considered, you know, not meeting our expectations and not meeting good practice. There needs to be more clarity around roles and responsibilities for certain services as we've outlined as such.

I agree as we see those schedules enhanced and improved, and then obviously with IT continually updating for, as described, new services that are added, that's fine. But right now we need to see more sufficiency, comprehensiveness, and then overall we would assess the service level agreement as adequate as such and continue to just assess that it's obviously like the expectations outlined in the service agreement are met from that service provider standpoint.

**Ms. A. Young**: — Thank you very much. And it's the expectation of eHealth that that will be achieved by spring 2024?

**Mr. Church**: — For this spring, by March 31st, 2024 we'll have progressed all of these schedules identified by the Provincial Auditor. They will not be fully complete and those recommendations not fully met by spring of 2024. We're targeting March 2025 to have met the auditor recommendation on the IT service agreement.

**Ms. A. Young**: — Thank you. So just to be clear, of the four risk areas that the Provincial Auditor identified, those without a functioning master services agreement — which I believe are disaster recovery, service levels, security requirements, and IT change management — do any of those key aspects have a completed master services agreement? Are any of those done or are all four still outstanding?

[09:30]

**Mr. Church**: — For the version that we are executing in the spring, we will have a full completion on the IT change management schedule as identified by the Provincial Auditor. We'll have substantial progress on the disaster recovery schedule which will be included in that. And between spring of 2024 and end of fiscal year '24-25 is where there'll be the completion of the service levels and the security requirements for a version 3 to be executed in the spring 2025.

**Ms. A. Young**: — Have any incidents occurred relating to any of the four areas identified by the auditor?

**Mr. Church**: — The work that we continue to do on these schedules outlines the processes and procedures that we'll follow and the service levels that we agree are acceptable to the SHA and that we can meet. So as far, you know, as the question, I would say the emphasis is really just quantifying the service levels and putting . . . documenting processes that are being followed today within the agreement.

**Ms. A. Young**: — Thank you. So to be clear, of those four risk areas identified by the Office of the Provincial Auditor, there have not been any incidents related to those four areas that would be addressed or identified by a master service agreement?

**Mr. Church**: — So certainly incidents do happen. Today we provide interim key performance indicators that we provide to the SHA on service levels. When those aren't kind of in

alignment in what's needed or expected, we review those with the Saskatchewan Health Authority on a regular basis and adjust to further bring our services into alignment of those interim key performance indicators. And these are really about, again, further defining and detailing things like service levels or processes that will be followed or requirements that need to be put in place in a written form within the agreement itself.

**Ms. A. Young**: — Thank you. So there have been realized risks identified by SHA to eHealth?

**Ms. Smith**: — Maybe just to sort of get a sense of kind of the scope of the questions, I guess how I would sort of provide that context is that on a daily basis there is obviously a lot of interaction between the Health Authority and eHealth as a service provider. And again the whole point around the recommendation and the whole point around the agreement and the schedules is just to have a really clear plan around when things do happen; you know, from the SHA's perspectives, here are the expectations in terms of what we need to see met from a service level provider.

So I think like contextually, when you think about a service between two organizations, and you know, one clearly . . . they have a role and they've got a series of services that they deliver on behalf into that organization, that's really the focus of the auditor's recommendations and that is the focus of eHealth. So just to give a bit of context so that maybe you can say your last questions sort of again just to make sure that we're honing in.

But I think that's where the reality is, is on a day-to-day basis there's a lot of interaction, there's a lot of service provided by eHealth to the SHA and to its employees. Really the intent here is to have the agreement and to have the clarity around what the expectations are so that there is clarity amongst the organizations and so that when the Provincial Auditor comes back, you know, again to take that review, again there is clarity around what the expectations are and there's a way to measure how they're being met.

**Ms. A. Young**: — Thank you. I was going to say I can imagine the scope of this project, but I actually can't. I'm sure it's massive.

To be clear, the point of my questions is the Provincial Auditor identifies that not having an adequate service level agreement increases the risk that eHealth fails to meet the Authority's IT needs, and this in turn could impact the likelihood that the Authority's systems are breached or unavailable for long periods of time.

So given the fact that the completion of this agreement has been outstanding now for a few years and continues to be referenced as an action undertaken to address the outstanding recommendations from the Provincial Auditor, I'm just trying to clarify whether or not any of the associated risks identified by the Provincial Auditor, due to the lack of finalization of key aspects of the IT service agreement, have actually been realized. You know, if the auditor is saying this increases the risk that these things could happen, have those things happened?

[09:45]

**Mr. Church**: — Thank you. It's important to note that even in the absence of an agreement and these things being put in the IT service agreement itself, within eHealth and within the services we provide, processes and procedures in all of these exist today. And so though they're absent in an agreed-to document with the Saskatchewan Health Authority, we have processes and protocols that we follow in each one of these areas today and that we employ. And so it's really just having them in an agreed-to written format within the document; it's not that these are totally absent and don't exist within the organization or within the services we provide.

**Ms. A. Young**: — All right. What's the total cost to date for legal services associated with this agreement?

**Mr. Church**: — We don't have that level of detail with us, but we can certainly follow up.

**Ms. A. Young**: — Perfect. Undertaking to bring information back to the committee.

**The Chair**: — Okay, thank you for that undertaking. Is the question clear as to what's being asked and then what's being committed to being brought back to the committee? Is that all sorted?

**Ms. Smith**: — I think so.

**The Chair**: — That's great. Is it reasonable to expect within four weeks or a one-month time frame to supply that back to the committee through the Clerk? Does that work?

**Ms. Smith**: — Yeah. We will work with eHealth and make every effort to get the information back in a timely way.

**The Chair**: — Yeah. That's appreciated. Thank you.

**Ms. A. Young**: — Thank you. Of the 35 critical IT systems eHealth is responsible for, how many have not yet completed disaster recovery testing? And how long will it take to complete this for all 35?

**Mr. Church**: — All 35 will have had their testing completed by March 31st.

**Ms. A. Young**: — Thank you. And for the committee's insight, is the testing similar for all 35 systems, or do they require like individualized testing? Can you speak to the delay, like what's contributed to that holdup?

**Mr. Church**: — Each of these systems and services, the process for the disaster recovery testing is unique. And being that they're all used in the delivery of patient care, we do have to ensure that the timing in which it's done and how it's performed doesn't impact medical services, and so there is a number of timing components that affect when and how we can do that as well.

**Ms. A. Young**: — Thank you. But it is expected they'll be completed by this spring?

**Mr. Church**: — All 35, yes.

**Ms. A. Young**: — Thank you. And just to clarify, has the five-

year disaster recovery road map been completed?

**Mr. Church**: — In '23-24 we completed a revised road map, using an external audit and assessment of that to develop that road map. And so in '24-25 we'll be executing on year one of that road map to continue our maturity in the disaster recovery.

**Ms. A. Young**: — Thank you. So, apologies, can you just clarify for me? My understanding from the auditor's report was that testing can't occur until the road map is complete. Am I incorrect in that understanding? I'm just trying to reconcile the timelines for the testing that's going to be complete and that 2025 deadline you just referenced for the road map.

[10:00]

**Mr. Church**: — As mentioned, we have the plans to complete our testing of the 35 applications by the end of the year. The road map that has been drafted and that we developed is around maturing that practice and maturing those testing practices in our broader disaster recovery program going forward.

**Ms. A. Young**: — Thank you. Can you be a bit more specific about that?

**Ms. Smith**: — If I could just clarify, in terms of more specific, do you have a more specific question just to help us here?

**Ms. A. Young**: — For sure. Apologies. I'm just trying to wrap my head around the process. And just basing it off the auditor's report, which I think lists the establishment of the 35 disaster recovery playbooks for the 35 critical IT systems is kind of priority one, and then disaster recovery is to begin after the five-year disaster recovery road map is completed. Is that accurate?

**Ms. Clemett**: — So I'll maybe just clarify some of the expectations that the road map envisioned is. So you've identified, or eHealth has, the 35 critical IT systems that they believe are key and therefore should be recovered in a timely manner in the event of a disaster. You have to have recovery time objectives. How quickly are we going to bring these systems back up in the event of a disaster — 24, 48 hours?

Some of those recovery time objectives — is what they're called, that are how fast are you going to recover — were not established yet, and that was part of the process that was anticipated within the road map implementation. It sounds like eHealth has now finalized that and will start the disaster-recovery-testing process whereby now you take those 35 systems, you have your recovery time objective, you test, and you figure out in actuality can you meet that objective or not.

The other thing is at the time of our discussions last year during the audit, there was the potential of a more staggered approach, which is potentially fine. It isn't necessarily . . . You know, ideally you want key systems probably to be tested potentially annually. I can see this, though, being on a more rotational basis, given there is 35 key systems. So we did envision there was a potential for a more staggered or lengthy approach, but it sounds like eHealth will be doing all systems in the next year and then potentially annually going forward. So we would just look at sort of the finalization and fulfillment of that.

**Ms. A. Young**: — Thank you. Thank you, Madam Auditor. Is that accurate?

**Mr. Church**: — Thank you. The testing that's being completed by the end of March will be ensuring that we can recover the systems. Those recovery time objectives form part of the service level agreements in the SSAs, service-specific agreements within the ITSA which are still being defined. And so our focus on this round of testing will be ensuring that we can recover the system.

As part of our annual testing, we will be doing annual testing of these 35. That will become part of not just the recovery testing, but also the meeting the objective of the RTOs [recovery time objective] that will be agreed to within the SSAs or the service-specific agreements within the IT service agreement.

**Ms. A. Young**: — And those SSAs are expected to be completed the same time as the remainder of the master service agreement?

**Mr. Church**: — That's correct.

**Ms. A. Young**: — Since these recommendations were last before the committee, have there been any security breaches to IT systems?

**Mr. Church**: — There have been infrequent or, you know, on a case-by-case basis incidents where users might click a link that they shouldn't and we recover their laptops and things like that. But there have been no broad operationally impacting incidents as a result to not having these schedules in place.

**Ms. A. Young**: — Thank you. Do you have a specific number in terms of how many security breaches to IT systems there have been and whether or not there have been any periods of time where systems were unavailable? And if yes, for how long?

[10:15]

**Mr. Church**: — There have been no security breaches since the cyber event of 2019.

**Ms. A. Young**: — Thank you. And has there been any feedback or concerns from the SHA about any eHealth outages or impacts to their work?

**Mr. Church**: — There have been outages that have impacted operations, as we've seen. Certainly, you know, we would define those is that there's access or availability of systems not available. And those could be for a variety of reasons. Those could be whether it be hardware fails or there's construction that has impacts on power lines or fibre lines. Those are all included in how we communicate.

So any time there's any impact to operations that relates to a system being out, regardless of the reason, we do communicate those and we have a process around working through and establishing and working with vendors or whoever needs to be involved to rectify that.

**Ms. A. Young**: — Thank you. If there's any documentation that could be provided that would include the numbers of periods where systems were unavailable as well as the reason, from the . . . kind of dating back to the last time these recommendations

were before the committee to present. Obviously we wouldn't ask for that right now, but on a go-forward basis if that's something that could be undertaken it would be appreciated.

**Mr. Church**: — Yes, we can provide that. And certainly we've seen those numbers trending down year over year.

**Ms. A. Young**: — Thank you. Mr. Chair, no further questions on this chapter.

**The Chair**: — Any further questions with respect to these two chapter 1s, respectively? Not seeing any, I'd welcome a motion to conclude consideration of both chapters. Moved by Mr. Goudy. All agreed? That's carried.

I'll turn it over to the Provincial Auditor and her team for chapter 15.

**Mr. Wandy**: — Thank you, Mr. Chair. eHealth Saskatchewan is responsible for managing critical IT services used to administer and deliver health care services in Saskatchewan, which includes portable computing devices that access the eHealth IT network. Almost 15,000 portable computing devices such as laptops and smart phones can access the eHealth IT network. Such devices create security risks for organizations because they are attractive targets for attackers, may become infected with viruses or malware, and are easy to lose.

Chapter 15 of our 2022 report volume 2 reports the results of our first follow-up of management's actions on seven recommendations we made in 2020 about eHealth's processes to secure health information on portable computing devices used in delivery of Saskatchewan health services from unauthorized access. By June 2022 we found eHealth implemented one of the recommendations and continued to work on addressing the remaining six recommendations.

We found eHealth implemented the recommendation on page 177 where we recommended eHealth Saskatchewan work with the Saskatchewan Health Authority to implement an annual security awareness training program for users of portable computing devices with access to the eHealth IT network.

In 2021 eHealth implemented an annual security awareness training program for all individuals accessing the eHealth IT network. We found the training program includes a module addressing mobile devices, and that eHealth monitors user completion rates for the training on a monthly basis. Ongoing training reinforces user awareness of good security practices to limit the risk of significant incidents and to protect the eHealth IT network from attacks such as malware.

We found eHealth partially implemented the second recommendation, on page 177, where we recommended eHealth Saskatchewan implement a written risk-informed plan to protect laptops with access to the eHealth IT network from security threats and vulnerabilities.

In 2021, eHealth implemented a centralized system to manage and configure laptops, updated its standard laptop configuration, and started upgrading laptops to the new standard. While eHealth made improvements to its standard laptop configuration settings, we found eHealth continues to permit unrestricted use of USB [universal serial bus] ports in laptops. Blocking USB ports can prevent devices from downloading data or uploading malicious software and tools. We found eHealth needs to complete a formal risk assessment to determine whether they are willing to accept the risk of users' ability to use the USB ports in laptops and their ability to access the devices' input/output settings.

eHealth partially implemented both recommendations. On page 179 we recommended eHealth Saskatchewan standardize the configuration settings for mobile devices with access to the eHealth IT network to mitigate associated security threats and vulnerabilities. We also recommended eHealth Saskatchewan analyze the cost benefits of use of a central mobile device management system to secure and monitor mobile devices with access to the eHealth IT network.

At June 2022 we found eHealth made improvements to mobile devices' auto lock settings and began piloting a central mobile device management tool, but it had not fully standardized its configuration settings for mobile devices with access to the eHealth network.

Our testing of eHealth's mobile device standard configuration settings found it continued to not align with good practice in a number of areas. These areas included weak password requirements, allowing the use of jailbroken and rooted devices on the eHealth network, and not restricting application downloads. Inconsistent configuration settings on mobile devices results in increased security risks. Well-configured security settings can protect the eHealth IT network from malicious software.

eHealth did not yet implement the recommendation, on page 181, where we recommended eHealth Saskatchewan take appropriate action to minimize the risk of security breaches when a portable computing device is reported lost or stolen. We found that while eHealth knows the extent of lost or stolen portable computing devices within its own organization, it does not have a mechanism to centrally track lost or stolen devices it manages for other health sector agencies.

We tested a sample of five lost or stolen devices eHealth manages for the Saskatchewan Health Authority. For four of the devices tested, we found eHealth was unable to find evidence that the Authority reported the devices to eHealth or that it appropriately wiped or removed the devices from the network. Not taking appropriate action to address lost or stolen portable computing devices increases the risk of unauthorized access to the network, putting personal health information at risk.

In regards to the final two recommendations, on pages 181 and 182 of our 2022 report volume 2, our office annually follows up on management's actions to address these recommendations about network access controls and monitoring. I will not describe our findings for these two recommendations at June 2022, as my earlier presentation about eHealth's integrated audit results for the 2022-23 fiscal year in our 2023 report volume 2, chapter 1, provided a more recent status update regarding management's actions to address these two recommendations as of March 2023. And both are yet to be implemented.

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

**The Chair**: — Thanks so much for the focus of the work. For those that are following, we've already considered these items at this table and concurred as a table. We appreciate the update on some of the actions that have been taken. I'd invite the deputy minister to provide a brief response, or her officials, and then we'll open up for questions.

**Ms. Smith**: — Thank you, Mr. Chair. I will just touch on . . . I recognize that I did jump ahead one chapter on a couple of these, but I'm just going to restate relative to the Provincial Auditor's comments.

[10:30]

So regarding the recommendation around implementing an annual security awareness training program, that was noted as completed in their '22 volume 2 report. eHealth introduced security awareness training for all employees in 2020. eHealth also consulted with health partner organizations to introduce the same security awareness training program. The Saskatchewan Health Authority is fully engaged and has committed to employee participation.

Surrounding the written plan to protect laptops, in 2022 eHealth introduced an access management policy and a network access policy. As of late 2023 all supported end-user devices have been standardized, which includes security-focused configuration and modern security tools including device encryption.

eHealth has implemented standardized configuration settings for mobile devices. In 2023 eHealth has upgraded 100 per cent of supported laptops and mobile devices across the provincial health system to a standard configuration. eHealth has completed standardization of a mobile device management solution.

For the cost benefit of a central mobile management system recommendation, eHealth has determined that a management system and standard should be utilized to manage devices across the provincial health system. eHealth has begun implementing an established common standard in a mobile device management system throughout the health system.

eHealth has implemented the recommendation surrounding taking appropriate action to minimize security breach risks for lost or stolen devices. eHealth can disable the device via management tools through the standard provincial response process and work standard.

Surrounding the recommendation for a risk-based plan to control network access, eHealth continues to implement an information security management system which determines security controls using a risk assessment approach. As part of ongoing modernization and security program priorities, additional technical and procedural capabilities have been implemented such as multi-factor authentication for email and VPN [virtual private network], data centre controls to control lateral traffic movement, and ongoing review and cleanup of stale and privileged accounts.

And finally, to implement the recommendation related to utilizing key network security logs and scans, eHealth is working with a vendor on establishing a managed service that will monitor logs for suspicious activity. Currently basic logs are created and used by eHealth to monitor and mitigate potential threats. Thank you.

**The Chair**: — Thanks for the work on these fronts. We'll open it up for questions. Committee members? Ms. Young.

**Ms. A. Young**: — Thank you very much. Looking to go through these somewhat sequentially, what's the latest count of portable computing devices that can access the eHealth IT network? And if possible — it doesn't have to be today — but is there a breakdown by smartphone, tablet, laptop, other types of devices that would be accessing this network?

And then my last question in this regard is if newly purchased hardware and devices come with the latest security settings installed, and are users able to change those?

**Mr. Church**: — Related to the question around the number of devices that can access the network, we can table that information. In relation to the question of, do devices that are provided by eHealth come with the latest security settings? Yes, they do. We have a standard image that we provide on those. And around the question of, can they be changed by the users? They cannot.

**Ms. A. Young**: — Thank you very much. And when that information is provided if it could be broken down based on device type, as deemed relevant, that would be great. Thank you.

So looking at the results in this chapter, it indicates that as of June 2022, 89 per cent of users had completed information security awareness training. Is that up to 100 per cent by now? Where are we at and what is the benchmark score for passing training? I'm thinking in particular of, I believe it was a phishing campaign that was done in 2021.

**Mr. Church**: — As far as the number for that 2022 training around the phishing campaign, 97 per cent of health sector staff have completed that training, and the passing grade aligns with the OIPC or the Office of the Information and Privacy Commissioner recommendation of a pass grade of 90 per cent.

**Ms. A. Young**: — Thank you. And for the sad 3 per cent of people who have failed, I'd imagine they have to complete additional training. And is there a specific time period in which they take that? Or do they just retake that test again?

**Mr. Church**: — I don't know the specifics of the 3 per cent. Again with the size of the health sector, right, there's lots of turnover so that could be people who just haven't completed it yet. It's a point-in-time number, those who have not yet completed it if they're new to their positions or to the health sector. So I can't really speak on what makes up that 3 per cent.

If there isn't a passing grade, they are required to retake the exam until which point they receive a passing grade.

**Ms. A. Young**: — Okay, thank you. And so if somebody continues to fail information security awareness training, is there additional training to them or do they just kind of retake it until . . .

**Mr. Church**: — There are additional supports that eHealth can

provide to those individual users. Generally it would be the user's manager that would reach out to us indicating that there's perhaps challenges with this individual passing the exam, and there's certainly additional supports that we can provide.

**Ms. A. Young**: — Thank you. So the same period of time, as of June 2022, 71 per cent of devices, it's indicated, used encryption. Is that up to 100 per cent by now?

**Mr. Church**: — The answer is yes. So with the completion of our Windows 10 upgrade, all eHealth-issued devices are now encrypted.

**Ms. A. Young**: — Great. Thank you. Sorry. And just going back to the previous question about the information security awareness training, I know we talked a little bit specifically about the phishing campaign listed in the auditor's recommendation. But that 89 per cent of users who've completed information security awareness training, what number is that up to by now? Is that the 97 per cent or was the 97 per cent specific to phishing?

[10:45]

**Mr. Church**: — The 97 per cent was for that initial training. Then there's a subsequent phishing campaign that partners can request whereby we would simulate phishing emails and identify if staff had clicked on links and whatnot that we can then provide further education to those individuals who perhaps do fall for those phishing campaigns.

**Ms. A. Young**: — Thank you. Continuing on with the recommendation around mitigating laptop security threats and vulnerabilities which was noted in progress, are there compliance updates or information that can be shared in regards to some of the other factors identified by the Office of the Provincial Auditor such as the risks identified around unrestricted use of USB ports, migrating the operating systems to Windows 10, some of those commitments undertaken at the time of writing? I'm just seeking to see if those were achieved.

**Mr. Church**: — The risk and recommendation regarding Windows 10 has been completed, so all devices have been replaced with Windows 10. Standard issue devices currently do not come with CD/DVD [compact disc/digital versatile disc] players anymore, so we feel that one's been recommended. And regarding the USBs, we continue to assess with the SHA the impacts to operations and workflow by not having the availability of USB ports on devices.

**Ms. A. Young**: — Thank you. And moving on, I'm looking for an update in regards to the latest standards for password settings. Do current devices allow password manager apps or features to save their passwords? Like are password managers permitted? And if yes, is there an approved list or is it choose your own adventure?

**Mr. Church**: — We have updated and strengthened our password requirements and policies. And we also as part of our security training involves how to protect and manage your password through the security training as well.

**Ms. A. Young**: — Thank you. So are password managers permitted then?

**Mr. Church**: — They aren't currently technically limited. There's no technical limitations. Our policies do provide advice around appropriate use of eHealth-identified or -provided assets and what types of software and whatnot people should be considering using or downloading and what they are advised not to.

**Ms. A. Young**: — Thank you. And then in regards to the other areas of testing related to eHealth's mobile device standard configuration settings identified by the office of the auditor on page 180 of chapter 15, for those that were outstanding, outside of good practice, has eHealth taken steps to align to suggested recommendations? And if not, I'd be curious in learning why.

**Mr. Church**: — So we have taken steps to address those key areas within mobile device management. So as examples, users are limited to download only approved applications that interact with the corporate data with a containerized device, so we have implemented the containerization as well as paired with the mobile device management. On those devices it does identify which types of downloads they can do. We have implemented auto lock on those devices as well.

We have also strengthened our password requirements within those devices. And then we continue to right now rely on the training also and policies of acceptable use around what things they should be accessing and downloading on devices that might not be restricted.

**Ms. A. Young**: — Thank you. Moving on to the next recommendation, does eHealth now have records of how many devices were lost or stolen and had to be disabled?

[11:00]

**Mr. Church**: — Since the last audit there were nine devices reported lost or stolen to us. And all had actions taken to immediately disable those devices.

**Ms. A. Young**: — Thank you. Of those lost devices, were any of them recovered? I don't even know if that's a fair question but . . .

**Mr. Church**: — I don't have that information with me.

**Ms. A. Young**: — Thank you. I don't know how relevant this next question is then. It was going to be if a device is recovered, is the data from that device recoverable or is it . . . If a device is lost and stolen and disabled, is that data then permanently wiped as soon as the loss is reported?

**Mr. Church**: — When a device is reported lost or stolen and we disable that, there is . . . The information is not recoverable at a later date that was locally stored on the machine.

**Ms. A. Young**: — Thank you. Moving on to the next recommendation focused on network access controls. It's indicated in chapter 15 that eHealth is working toward centralized network access controls for all health sector agencies and network access ports with a target date for piloting this work by the end of March 31st, 2023. Did that occur?

**Mr. Church**: — That pilot continues to be under way, and per

the auditor statements in the report, we anticipate completing that in ’24-25.

**Ms. A. Young**: — Pardon me, I missed the last part of your statement.

**Mr. Church**: — Just per the references within the auditor’s report in that chapter that we do anticipate completing that in ’24-25.

**Ms. A. Young**: — By ’24?

**Mr. Church**: — In ’24-25.

**Ms. A. Young**: — ’24-25. Thank you. So the actions taken to implement since the auditor’s report indicated in the status update around the implementation of an information security management system, it says that they’re under way. This is the ongoing pilot? Or are these two distinct projects? Forgive me.

**Mr. Church**: — If you can just repeat the question, just so I can address it in the proper order there.

**Ms. A. Young**: — Sure. So looking at section 3.5, network access controls needed, in chapter 15 on page 182 it is indicated that, and I quote:

> eHealth is working towards centralized network access controls for all health sector agencies and network access ports. eHealth plans to pilot network access controls in one medium and one large healthcare facility (e.g. hospital) by the end of March 31, 2023, with full rollout timelines determined after the pilot program.

Which you’ve indicated did not occur, and the piloting is still ongoing, projected to be completed next year. And then in the status update provided by eHealth, speaking to the same recommendation, it’s indicated under the section “actions taken to implement since Provincial Auditor report,” implementation of an information security management system is under way.

And so I’m just trying to clarify. Are these the same project? Are these two distinct projects? And if the latter, can you expand on what the information security management system is and how it’s speaking to the outstanding recommendation? Thank you.

**Mr. Church**: — The information security management system, or ISMS, is a broader program being established within the organization for us to move towards ISO 27001 security program standards.

Within that we have a number of . . . we have a road map with a number of objectives that lay out the various steps that we’ll be taking over the coming years. And currently the work under way to address the recommendation within this chapter around the key security logs is related to the ISMS work which is around the 24-7 monitoring and reviews where we’re working with the third-party providers for 24-7 monitoring services.

**Ms. A. Young**: — Thank you. And the ISMS project, that began when?

**Mr. Church**: — So following the 2019 ransomware event, we had done a third-party assessment of our cybersecurity maturity which outlined that we should be moving towards a more standard approach to security. And so we had chosen the ISO 27001 standard to move towards and have built our security program around, or ISMS program around ISO 27001.

**Ms. A. Young**: — Thank you. And that’s still expected to be operational by ’23-24?

**Mr. Church**: — That would be an ongoing program that would manage our security operations in general, of which they have a road map which we’re moving into year three of a five-year road map. And every 18 months we reassess that road map and reassess the maturity against our progress towards that ISO standard.

**Ms. A. Young**: — To the auditor, that’s an appropriate ISO standard to be . . .

**Ms. Clemett**: — Correct. Yes, it is. Yeah.

**Ms. A. Young**: — Thank you. So going back then to the network access controls, is there a new target for when that will be achieved? You’ve said kind of 2024, 2025, but wondering if it is possible to be at all more specific, as well as if there is any clarity and specifics that could be provided as to account for the delay?

[11:15]

**Mr. Church**: — We anticipate that pilot to be complete as referenced by March ’24-25. The reasons for the delay was really to refocus efforts within some access controls within the data centre that . . . There’s also infrastructure replacements that would actually be prerequisites to this pilot that had to be done, and then also do some further analysis, really, that focused around what are the appropriate tools for this work.

**Ms. A. Young**: — Thank you. And specifically to the infrastructure requirements, going off the information in the report, it notes that this pilot was to roll out in two facilities, so one medium and one larger health care facility. If there were infrastructure requirements in order to launch the pilot, is this something that’s expected on a more system-wide basis? I suppose what I . . .

**Mr. Church**: — So again this was IT infrastructure within our data centre.

**Ms. A. Young**: — Okay. Pardon me. Not in the other . . .

**Mr. Church**: — Not broader, but IT infrastructure within our data centre had to be implemented prior as a prerequisite to this.

**Ms. A. Young**: — Okay. Thanks. Thanks for that clarification. And just circling back quickly to the ISMS, can you remind the committee the contractor being used for that program as well as the budgeted cost associated with it?

**Mr. Church**: — Thank you. The ISMS program doesn’t have a direct contractor. That’s a program that we have established internally, and we have a third party on a point in time basis come in and audit that.

If you're referring to the projects around the 24-7 monitoring and those contracts are what you're interested in, I don't have the exact values with me. We can certainly table those, but they were also, once awarded, made available on SaskTenders as to who was awarded and the total contract value was made available on SaskTenders publicly as well.

**Ms. A. Young**: — Great. Thank you. Yeah, more looking if there's any deviance from those initially awarded tenders either in terms of scope or the value of the contracts, but yeah, appreciate it if that could be made available to the committee.

Moving on to the last recommendation, it's indicated that there are basic security logs to detect malicious network activity. Not being an expert in this, what information do basic security logs provide? And what else will be added when eHealth has . . . Forgive me, I'm not sure what the right word is. But logs that would not be deemed basic, how will this evolve or mature?

**Mr. Church**: — Related to the question of what does basic log, what information do those have, that would be various information about the users or a user, about IP [Internet Protocol] addresses and so forth. And so while that information is used, there's also other advanced-threat tools scanning the environment, providing additional information as well. And so all the network logs that are provided would have basic information.

We've also taken steps to implement other tools that are consistently scanning the information or environment and providing other pieces of information as well.

**Ms. A. Young**: — Thank you. And the timeline for that is identified in the status update of '23-24. That remains a targeted timeline for getting this fully up and running?

**Mr. Church**: — So that project is under way currently, yeah.

**Ms. A. Young**: — And then a similar question for this. The vendor and the initial cost for the procurement on those services to monitor the logs, do you have that available?

**Mr. Church**: — So that is in relation to the one we said that we would provide, and that one is also available on SaskTenders. It's the same work.

**Ms. A. Young**: — Great. Thank you. Mr. Chair, no further questions on this chapter.

**The Chair**: — Looking to committee members to see if there's any further questions with respect to chapter 15. Not seeing any, I would welcome a motion to conclude consideration of chapter 15. Moved by Ms. Lambert. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's carried. Moving right along, we're going to shift to the Saskatchewan Health Authority. Now I don't know if Mr. Church from eHealth and other officials are going to be sticking around or not, or if they're . . . I just want to say thank you for your presence here today and your work day in, day out, and your attention to following up on some of the undertakings of information back to this committee as well. I will turn it over to the Provincial Auditor to focus on the chapters around the Saskatchewan Health Authority, and I think the first focus is chapter 5.

**Ms. Clemett**: — So thank you, Mr. Chair, Deputy Chair, committee members, and officials . . . [inaudible interjection] . . . I think there will be, yeah. And so you want them to do introductions first?

**The Chair**: — Yeah, good point.

**Ms. Clemett**: — Sure.

## Saskatchewan Health Authority

**The Chair**: — So just identifying that we've had . . . I guess we're switching our focus here to the Saskatchewan Health Authority. DM [deputy minister] Smith, I'm just seeing if you want to make any remarks or parting words with respect to the folks around eHealth and any new officials to introduce before we shift into the SHA chapters.

**Ms. Smith**: — Thanks, Mr. Chair. So again, thank you to Davin, John, and Lillian for answering those questions and for the work that they've done to advance many of those recommendations.

With respect to the Saskatchewan Health Authority, we do have a few people that are joining us from the Authority today to help answer some questions. And maybe what my approach will be is I will sort of name some of the individuals joining us, and then as they come up and answer questions they can state who they are.

But I would like to just introduce . . . We have Derek Miller, who is the chief operating officer for the Authority. We've got Kelly Thompson, the vice-president of finance and chief financial officer. As well we've got Bryan Witt, the VP [vice-president] of provincial clinical and support services. I believe that Mike Northcott, the chief human resources officer is here along with Michelle Mula, the VP of quality, safety and the chief information officer.

And I'm just going to validate to . . . I think we've got pretty much the full team, so I'd also just like to welcome John Ash, the VP of integrated Saskatoon health; Brenda Schwan, the VP of integrated rural health joining us today. There were a couple of individuals not available just with weather issues, but I would like to welcome them and again look forward to the series of questions that we'll get this afternoon. Thank you.

**The Chair**: — Well thanks so much, DM Smith, and thanks and welcome to all those officials. Thanks again to the eHealth folks that were with us here this morning. And just a reminder as the DM identified, if you're taking a microphone, if you can just introduce yourself.

[11:30]

The DM doesn't need to do that. We've got her all teed up there. But anyone else coming to the microphone, if you can just state your name and position before you enter in. I'll turn it over now to the Provincial Auditor.

**Ms. Clemett**: — So thank you, Mr. Chair. To my left is Mr. Jason Wandy. He's the deputy provincial auditor for the health division, and he's responsible for the audits at the Saskatchewan Health Authority.

Jason's going to present the chapters on the SHA in the order that they do appear in the agenda. This will result in 12 presentations. He's going to pause after each presentation for the committee's discussion and deliberation. There are three presentations that will include 16 new audit recommendations for the committee's considerations, and nine presentations that are follow-up audits where we have assessed the status of outstanding recommendations that we have made in an original performance audit.

I do want to thank — I know he's not here — Andrew though, the CEO at the SHA, for the co-operation, and obviously all the executive members at the SHA for the various assistance that is extended to us during the course of our audit work. With that I'll turn it over to Jason.

**Mr. Wandy**: — Thanks, Tara. Chapter 5 of our 2022 report volume 1 reports the results of our audit of the Saskatchewan Health Authority's processes for the period ending February 28th of 2022 to purchase goods and services over $5,000. We concluded the Authority had effective processes other than in the areas reflected in our eight recommendations.

A number of our recommendations support the Authority's need for having a centralized IT system to store purchasing documents. The Authority purchases capital assets, goods, and services to support the delivery of health services each year. During fiscal 2020-21 the Authority purchased approximately $483 million in goods and services directly, which included about $170 million in capital asset additions.

The Authority maintains a comprehensive procurement policy that sets reasonable dollar value thresholds to guide staff on which purchasing method to use. This could include obtaining competitive quotes or issuing a formal, public, competitive bid document. The Authority's policy also sets out guidance for when staff can use non-competitive purchasing methods such as single- or sole-source purchases.

On page 75 we recommend the Saskatchewan Health Authority follow its single- and sole-source requirements when using credit cards to purchase goods and services over $5,000. At February 2022 the Authority had assigned 611 credit cards to staff. Except for certain staff with high single-transaction limits, the Authority expects staff to generally use credit cards to buy small-dollar-value items for purchases less than $5,000.

Between April 2020 and November 2021 we found staff made 41 purchases on credit cards in excess of $5,000, ranging from just over $5,000 to $34,500 in value.

We tested a sample of 32 of these transactions and found the Authority did not always comply with its procurement policy for these purchases, therefore may not have obtained best value in all instances.

For example, we found 15 transactions where the Authority obtained goods or services from a sole or single supplier and did not document rationale nor approval to do so. Of these 15 transactions, we found three instances where we determined the Authority should have obtained three quotes prior to selecting the suppliers, and six instances where staff did not complete the sole-source and exceptions justification form as expected by the Authority's procurement policy.

When the Authority does not follow its procurement policy when using credit cards to purchase goods and services over $5,000, it is at risk of not treating suppliers fairly and equitably and may not obtain best value in making purchasing decisions.

On page 76 we recommend the Saskatchewan Health Authority follow its procurement policy, for example document rationale when using single- or sole-source purchasing methods. We tested 23 single- or sole-source purchases made by the Authority. These purchases included buying goods and services such as water purification systems and software licences.

Our testing of these purchases found the Authority neither consistently documented rationale nor sought approval for the use of single- or sole-source purchases as expected in its procurement policy. For example, we found the Authority did not complete the justification form for 17 purchases we tested.

When the Authority does not follow its policy when using single- or sole-source purchasing, the Authority is at risk of not treating suppliers fairly and equitably and may not obtain best value in making purchasing decisions.

On page 77 we recommend the Saskatchewan Health Authority authorize the initiation of purchases consistent with its delegation of signing authority. The Authority uses either contracts or purchase orders as legally binding purchase documentation. Only Authority staff with written delegation of signing authority are authorized to sign contracts and purchase orders on behalf of the Authority. They require staff to issue purchase orders for purchases between $5,000 and $75,000. For purchases greater than $75,000, the Authority's procurement department determines sources of supply through the public tender process and complete a procurement confirmation form for approval by senior management.

We tested 41 purchases and found the Authority did not properly authorize the purchase orders for two purchases, such as a manager approving a purchase over $50,000 instead of the appropriate director. In addition, we found the Authority did not properly approve the procurement confirmation form in four instances. The Authority was also unable to provide us with either the procurement confirmation form or the purchase orders for a number of purchases. Inappropriate approvals for purchase initiation increases the risk of the Authority committing to purchases that do not meet its needs.

On page 79 we recommend the Saskatchewan Health Authority consistently evaluate suppliers when tendering for the purchase of goods and services. The Authority uses subcommittees to conduct each of its public tenders, typically including purchasing staff, subject matter experts, and individuals with prior experience about the type of purchase. Subcommittee members use tender evaluation criteria to score each bid received on a tender. Purchasing staff combine the results from the subcommittee members within a scoring matrix to provide an

overall score for each proposal.

We tested 13 tenders and found the Authority used the subcommittee to evaluate the bids for 10 of these tenders. In one instance we found the evaluation criteria used by the subcommittee members did not align with the criteria the Authority communicated in the tender documents. While we found this oversight did not impact the Authority's award decision, having differences in weighting from the original evaluation criteria does not align with good practice and decreases the evaluation process's transparency. This can increase the risk of dissatisfied suppliers or not selecting the appropriate supplier based on the established criteria.

For the three tenders where the Authority did not use a subcommittee, we found it received only one bid for two of the tenders and the Authority did not use the evaluation criteria to assess the suppliers. The Authority was unable to provide us with the evaluation support for the third tender worth $726,000, therefore we do not know whether the Authority fairly evaluated suppliers and awarded the contract based on best value. Not properly completing evaluations for all tenders increases the risk of selected suppliers not sufficiently meeting the Authority's needs. Without documented evaluations, the Authority cannot sufficiently support its decisions for supplier selection and demonstrate achievement of best value.

Also on page 79 we recommend the Saskatchewan Health Authority obtain conflict-of-interest declarations from tender subcommittee members as required by its conflict-of-interest policy. The Authority's procurement policy requires tender subcommittee members to declare any potential or perceived conflicts of interest in accordance with the Authority's conflict-of-interest policy. For 5 of the 13 tenders we tested, the Authority was unable to provide us with the subcommittee members' completed conflict-of-interest declarations. Staff with real or perceived conflicts of interest may be biased in their decision making. Not requiring subcommittee members to complete conflict-of-interest declarations or not effectively maintaining declarations increases the risk of the Authority not being able to illustrate fair and equitable treatment of potential suppliers.

On page 81 we recommend the Saskatchewan Health Authority consistently communicate supplier award decisions for public tenders as required by its procurement policy. Once the appropriate signing authority approves the recommended supplier for the tender award, the Authority notifies the successful bidder with a letter of intent. It also sends letters of regret to all unsuccessful bidders after it signs the contract with the successful bidder. In addition, the Authority requires staff to publicize contract award notices within 72 days of awarding the contract, such as posting notices on the SaskTenders website.

We analyzed the status of 171 public tenders the Authority completed between April 2020 and February 2022. We found the Authority did not post contract award information on SaskTenders for approximately 75 per cent of its public tenders during that period. Not communicating supplier award decisions makes it difficult for the Authority to demonstrate that its purchasing process is fair and transparent, and it may be in violation of external trade agreements.

On page 82 we recommend the Saskatchewan Health Authority authorize contracts for goods and services in accordance with its delegation of authority. After the Authority approves a recommended supplier, it will enter into a contract with that supplier. This is done through a written contract or a purchase order.

During our testing of purchases the Authority made through tenders, quotes, and a single- or sole-sourced purchasing methods, we found one written contract not signed by either the Authority or the supplier, and five contracts not approved in accordance with the Authority's delegation of signing authority. The Authority was unable to provide us with the related purchase order or written contract for 11 purchases. Therefore we were unable to assess the authorization associated with these contracts. Not executing contracts in accordance with expectations, such as not in accordance with the delegation of signing authority, increases the risk of the Authority making inappropriate purchases, being vulnerable in contract disputes, and not receiving expected goods or services when needed.

In the final recommendation, on page 84, we recommend the Saskatchewan Health Authority establish a formal process to assess and track supplier performance. The Authority supply chain staff meet daily to discuss supply chain issues and upcoming purchases. They maintain a daily huddle action log to track progress on supply chain issues and help monitor resolution.

A review of the action log between August 2021 and March 2022 found staff did not note any supplier performance issues. Inconsistent with good practice, the Authority does not formally assess whether suppliers performed to a satisfactory level such as meeting timelines or the quality of their work after the conclusion of the contract or after its receipt of goods and services. Assessing suppliers at the conclusion of a contract is important as assessments can affect whether suppliers are selected for future projects. Without a consistent process to assess and track supplier performance the Authority increases its risk of using unqualified or inappropriate suppliers.

I will now pause for the committee's consideration.

**The Chair**: — Thanks so much for the focus of the chapter. These are new recommendations before us here today. We've already got the status update from the deputy minister. I would encourage her to speak briefly to some of those actions, and then we'll open it up for questions.

**Ms. Smith**: — Thank you, Mr. Chair. Surrounding the recommendation for the Saskatchewan Health Authority to follow its purchasing policies when using credit cards, all cardholders were reminded of the compliance requirements, and training on policies is mandatory for new cardholders and approvers. Additionally the SHA reviews transactions over $5,000 monthly to ensure ongoing compliance with policies. These reviews are documented, and non-compliance with policies are followed up on with both the cardholder and the approver.

Regarding the documenting of a single- or sole-source purchases recommendation, the SHA has updated its contract award summary form to document procurement decisions and provide clarity on requirements of procurement policies and processes.

The updated form ensures a comprehensive record of the procurement process is maintained, including the description of the product or service, process specifics, evaluation summary, evaluation recommendation, contract terms and value, compliance with signing authority policy, and document storage. Additionally, the updated form includes a disclaimer to be signed by the contract owner, procurement director, and manager confirming that all information is accurate and complies with all Saskatchewan Health Authority policies.

In regards to the recommendation for complying with a delegated signing authority, leaders across the Saskatchewan Health Authority received reminders of the requirements contained within the delegation of signing authority policy in September of 2022. Additionally, the senior leaders within the finance portfolio followed up directly with those individuals not complying with the delegation of signing authority policy. New employees receive training on policies and processes required to understand the delegated signing authority as part of their orientation.

To implement the recommendation to evaluate potential suppliers during tendering, the Saskatchewan Health Authority has updated its procurement processes to include these activities. To achieve this, the procurement area within the Saskatchewan Health Authority has implemented the contract award summary form which includes standard categories for evaluation that are utilized as applicable to the procurement subject.

Regarding the recommendation for conflict-of-interest declarations, the Saskatchewan Health Authority's procurement checklist has been updated to ensure all necessary conflict-of-interest declarations are signed and retained. The procurement process has been updated to require a conflict-of-interest form being completed by all subcommittee members during the competitive process. Recurring members will sign the conflict-of-interest form each time.

[11:45]

Surrounding the recommendation to communicate supplier award decisions, the procurement checklist was updated in September 2022 to ensure the notification-of-award step is completed on SaskTenders for all procurements. Additionally on a quarterly basis, both the manager and director of procurement review a report for all awarded procurements and ensures all corresponding notifications were sent.

To implement the recommendation to have contracts authorized appropriately, leaders across the Saskatchewan Health Authority received reminders of the delegation of signing authority policy requirements in September of 2022. Additionally the contract award summary form was implemented in December of 2022. The form, which includes contract value and contract approver information, is reviewed by the manager and director of procurement who confirm the correctness of the signing authority. This is done for all contracts that are managed through the procurement process.

Surrounding the recommendation to assess and track supplier performance, the Saskatchewan Health Authority has developed a formal process to assess and track supplier performance. To complete assessments of supplier performance, the SHA director of procurement now joins 3sHealth [Health Shared Services Saskatchewan] in all performance reviews. These reviews include an evaluation one year after contract implementation and reporting results and, when required, necessary corrective action. Ongoing monitoring of performance throughout the life of the contract takes place and again, if required, feedback is provided. The evaluation process is also followed prior to the SHA extending a contract for any optional years. Thank you.

**The Chair**: — Okay. Thanks so much for detailing some of the work on this front and to those involved in this work. I'll open it up now to committee members for questions. Ms. Young.

**Ms. A. Young**: — Thank you very much, Mr. Chair. Jumping right into it, I understand that recommendations 4 and 5 are fully implemented and that processes are being used to consistently evaluate suppliers and obtain conflict-of-interest declarations. So just to confirm the information you just provided to the committee, there's no full compliance with those recommendations, is that correct?

**Ms. Smith**: — Thank you. I'm going to invite Kelly Thompson from the Saskatchewan Health Authority to answer your question. Thank you.

**Mr. Thompson**: — Thank you for the question, and an excellent question. So as part of that implementation of that standard, we've also implemented a secondary review that takes place by the procurement team as well, that ensures that when that checklist is complete that they also review that the forms are attached and that process has taken place. So that's how we're ensuring compliance, is that secondary review that we've implemented.

**Ms. A. Young**: — Thank you. And is that specific to the evaluation of potential suppliers or the conflict-of-interest declarations from tender subcommittees as well?

**Mr. Thompson**: — Yes, I can confirm that's for both of those processes.

**Ms. A. Young**: — Thank you very much. Moving on to recommendation no. 6 pertaining to communication of supplier award decisions for public tenders as is required by the procurement policy, it's noted that the period of time from April 1, 2020 to February 2022, the Authority publicly tendered 171 new contracts. Is information available in regards to how many contracts have been tendered from February 2022 to present as well as whether or not all of these had the appropriate information posted on SaskTenders?

**Mr. Thompson**: — So I can bring back the actual number of tenders during that time. I don't have that handy right now. But I can confirm since the policy was implemented in 2022, it has been followed and our procurement team on a monthly basis sits down to review the tenders that were awarded and also ensures that they were posted to the public domain as well since that time.

**Ms. A. Young**: — Thank you. Thank you for that undertaking. And the list of tenders that you're bringing back, is that currently publicly . . . All of that would be publicly available still through SaskTenders? Or if I'm looking backwards, is that information . . .

**Ms. Smith**: — Thanks for the question. So the SaskTenders is managed by SaskBuilds and Procurement, and so there is historical information that is on that website that includes the Saskatchewan Health Authority for all of the procurements that it does.

So what I would say is that the information from, again, from what we can tell, it's there. It's historical. But for how long that information stays up, that really falls . . . That would fall outside of the Saskatchewan Health Authority sort of decision and policy. That falls under SaskBuilds.

**Ms. A. Young**: — Okay, well thank you for that, hearing there is an undertaking to provide context for those tenders that were awarded.

**The Chair**: — And, Member, maybe I'll just . . . Thanks so much for the undertaking on that good question. I'll maybe just enter here because we have a new entity with us. Thanks for that undertaking.

Is it reasonable to have that information then provided within the next four weeks, one month, to this committee through the Clerk?

**Mr. Thompson**: — Yeah, that's no problem.

**The Chair**: — Cool. Okay, that's great. Thank you very much for that.

Seeing that it's 12 o'clock, I'm just going to interject. We'll take a brief recess here for a bite to eat or meetings, whatever you need to do. We'll just pick things right back up at 1 o'clock and just keep following our programs. Thank you very much.

[The committee recessed from 11:59 until 12:58.]

**The Chair**: — Okay folks, we'll resume consideration of chapter 5 with the Saskatchewan Health Authority, chapter 5 of the auditor's report, and we'll continue back to the questions. Looking over here to see if anyone's on deck. I know Ms. Young was on deck with a question when we had our recess. Ms. Young.

**Ms. A. Young**: — Thank you. Thank you very much, Mr. Chair. Returning to recommendation 6 from the Provincial Auditor pertaining to improved communication of supplier award decisions needed, in chapter 5 of the auditor's report it's noted that between April 1st, 2020 and February 28th, 2022, the Authority received two complaints. And one complaint was resolved and the other complaint was still in the process of being resolved.

I'm wondering if you can update the committee on the status of that second complaint, as well as detailing kind of what that resolution process looks like, whether there are any current complaints, and what, if any, costs are associated with those.

[13:00]

**Mr. Thompson**: — On that specific outstanding complaint at that time, I'll have to follow up with my team for more details on that. So I'll follow up and I'll bring it back, an update on it, as well if there's any other outstanding complaints at this time.

**Ms. A. Young**: — Thank you very much. Moving on to the partially implemented recommendation, recommendation no. 8 in regards to a formal process to assess and track suppliers. It notes that the process is partially implemented and it also notes that the timeline for implementation is TBD [to be determined]. Are you able to share with the committee some rationale to . . . a little bit more information on what that process looks like and why the timeline is TBD?

**Mr. Thompson**: — So this item, it would be partially implemented. So we have partnered with 3sHealth on the contracts that they manage for us to evaluate supplier performance, and that's something our procurement team partners with 3sHealth on. And we evaluate the vendors from everything from quality, performance, a variety of metrics to assess what their performance is. Then we grade them based on a criteria of red, yellow, or green based to what the standards that we have.

And if they're red or yellow, we'll come up with an action plan to work with that vendor on and get that put into place. And that process with 3sHealth covers about 50 per cent, close to that, of the goods and services that we purchase. It wouldn't quite be that but it would be close to that.

And for the remaining 50 per cent that SHA manages the contracts of, the team is just currently, as we speak, developing and formalizing what that criteria would be to evaluate those vendors, leveraging the process that we have in place for 3sHealth. And our plan is to have a pilot rolled out on that in the next fiscal year.

**Ms. A. Young**: — Thank you. And perhaps just one last question on this chapter to the Provincial Auditor. Recognizing there's a number of new recommendations, do the actions described by the status update as well as the good folks here today, do you feel they represent, like, appropriate implementation of the actions recommended by the Provincial Auditor?

**Ms. Clemett**: — So in terms of us evaluating, I guess, the actual implementation of these recommendations, that will be coming forward, I believe it's fall or winter of sort of the '24, 2024, probably publishing out in '25 v.1. But I would say that based on the recommendations we made, we envisioned a lot of them being relatively easy to implement. And so in terms of the actions that the SHA has described they have undertaken, yeah, I do anticipate the next time we go, I hopefully look forward to seeing all these recommendations implemented.

**Ms. A. Young**: — Thank you very much. Mr. Chair, no further questions on this chapter.

**The Chair**: — Just one before we open it up to see if there's any others here. Just from page 78 of the report, the auditor identifies a tender worth $726,000 where she, I think, identifies that the proper evaluation support didn't accompany it. Just what was that tender for and who was it with?

**Mr. Thompson**: — I'll follow up with the team on that one as well and get more details on that.

**The Chair**: — Right on. Thank you. And that'll be within a month, back through the Clerk to supply that information. Is that

all right?

**Mr. Thompson**: — No problem.

**The Chair**: — Thank you very much. Any further questions with respect to this chapter? I'd welcome a motion to concur and note compliance with respect to recommendations 1, 2, 3, 4, 5, 6, and 7. Moved by Mr. Harrison. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's agreed. That's carried. I would welcome a motion to concur and note progress with respect to recommendation 8. Moved by Mr. Goudy. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's carried. Okay, we'll move right along here and I'll turn it back over to the Provincial Auditor. She's going to be focusing on chapter 12.

**Mr. Wandy**: — Thank you, Mr. Chair. The Saskatchewan Health Authority's human resource department is responsible for recruiting the Authority's 35,000-plus workforce, not including physicians, and for executing retention strategies. It routinely hires, organizes staff orientations, provides training opportunities, and administers benefit plans for staff.

At March 2022 the Authority identified 31 hard-to-recruit positions, with eight positions deemed hard to recruit because the vacancy is located in either rural or northern Saskatchewan. Chapter 12 of our 2022 report volume 2 reports the results of our audit of the Authority's processes for the 12-month period ended March 31st, 2022 to fill hard-to-recruit health care positions.

We concluded the Authority had effective processes other than in the areas reflected in our seven recommendations. Hard-to-recruit health care positions include those jobs responsible for directly delivering health care services where the Authority experienced difficulty in recruiting and retaining staff with the competencies required for the role. Our audit did not include physicians or positions responsible for administration at the Authority.

On page 142 we recommend 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.

In June 2022 the Authority issued its first comprehensive workforce plan covering the 2022 to 2026 period. Our review of the Authority's plan found it contained the major elements required of a workforce plan: supply, demand, gaps, and planned solutions. The plan includes a workforce supply and demand analysis for hard-to-recruit positions, with the Authority expecting about 765 staff in hard-to-recruit positions to terminate their positions within the organization each year, along with hiring close to 1,100 new staff each year.

However the plan still shows a shortfall in certain hard-to-recruit positions due to staff needed for new health care initiatives and current long-term staff vacancies. The Authority expected a shortfall in staff resources for hard-to-recruit positions of almost 2,200 positions over the next five years, with its largest staffing gaps in positions for registered nurses or registered psychiatric nurses, continuing care assistants, and medical laboratory technicians. These positions can have a significant impact on the ability to deliver health care services in hospitals and long-term care homes.

Our review of the Authority's plan found it does not identify staffing gaps by health care facility location, which could help drive the recruitment and retention strategies required. Our analysis of data the Authority used to support its gap analysis found it estimates new initiatives requiring over 700 additional staff in Prince Albert, Meadow Lake, and La Ronge over the next five years alone. This represents a significant staffing challenge for the Authority, as it can be difficult to recruit staff to rural and remote areas, particularly in the North, and will require targeted plans.

An analysis of expected staffing gaps by facility location across the province would assist the Authority in determining where it needs staff most and help it prioritize and tailor its recruitment processes accordingly. Doing so should also help the Authority to minimize service disruptions to the public.

On page 147 we recommend the Saskatchewan Health Authority implement targeted plans to address recruitment and retention for specific hard-to-recruit positions where it expects to have significant gaps. The Authority has generalized staff sourcing strategies for all health care positions in its workforce plan. Some of these strategies address hiring gaps as well as retention for hard-to-recruit positions. Examples of strategies include conducting career fairs at Saskatchewan's post-secondary institutions, advertising and social media recruitment campaigns, and purchasing training seats.

We found the Authority developed recruitment plans for some of its hard-to-recruit positions. These plans listed the actions the Authority expects to carry out in the next year. We assessed the Authority's recruitment plans for a sample of hard-to-recruit positions and found the plans lacked consideration of certain key areas such as varied sources of qualified staff and consideration of root causes of hard-to-recruit positions.

[13:15]

A lack of documented root cause analysis is a concern. If the Authority does not know why it cannot recruit and retain staff, it can be difficult to build plans to address the underlying issues.

For example, if the Authority expects to have a shortage of continuing care assistants in La Ronge over the next five years, targeted strategies can help the Authority focus its efforts towards addressing identified root causes specific to rural and remote recruitment. Such strategies could include the establishment of professional networks to support and mentor staff, or working with the local community to provide social supports such as assistance finding housing, daycare, or spousal employment.

The Authority posts service disruptions at various health care facilities across the province on its website. Our analysis of the website as at July 2022 found a couple of service disruptions in health care facilities specifically due to health care staffing

shortages in Kamsack and Biggar.

Further expansion and variation of its strategies to fill hard-to-recruit positions will be necessary for the Authority to limit further service disruptions to the public. Having an understanding of where in the province it expects to experience significant resource gaps may help the Authority implement appropriate targeted plans.

On page 148 we recommend the Saskatchewan Health Authority analyze whether clinical placements for students are a successful recruitment strategy for hard-to-recruit positions.

Annually the Authority creates clinical placement opportunities across the province for about 4,500 health care students enrolled at Saskatchewan post-secondary institutions, with some of these placements for hard-to-recruit positions.

The Authority provides supervision and training for the majority of clinical placement students. However we found the Authority does not have a system to monitor student placement and performance, or to track the number of employees it attracts as a result of these initiatives.

In addition, while post-secondary institutions may conduct student experience surveys, the Authority does not receive this information in a centralized way or conduct its own surveys to gain insight into student perspectives of the program or their views of the Authority as a potential employer.

Clinical placements are an important recruitment strategy that the Authority is uniquely positioned to use. The Authority needs to assess whether this strategy effectively helps to address its gaps in hard-to-recruit positions. Measuring the success of the strategy will enable the Authority to consider the root causes of any failures and make necessary adjustments.

On page 151 we recommend the Saskatchewan Health Authority periodically determine whether post-secondary training seats purchased out of province are successful at addressing vacancies for hard-to-recruit positions.

The Government of Saskatchewan, through the Ministry of Advanced Education, signs interprovincial agreements to purchase training seats related to health care education at Canadian post-secondary institutions outside of Saskatchewan. This type of training is required for several hard-to-recruit positions such as respiratory therapists. The government purchases the training seats to allow students who are Saskatchewan residents that meet the post-secondary educational requirements to access specialized health care training outside of the province.

For the 2019 to 2022 period, the Ministry of Advanced Education spent an average of just over $2 million annually on securing these training seats available to Saskatchewan students who qualify for entrance into the respective post-secondary institutions. We found neither the Ministry of Advanced Education nor the Authority have a system to readily monitor student placement and performance or to track the number of students who return to the province to work upon completion of their studies. A lack of monitoring whether students using government-purchased seats return to work at the Authority increases the risk that public money is not well spent. If purchased seats do not effectively address staffing variances, the Authority should consider adjusting its approach.

On page 154 we recommend the Saskatchewan Health Authority implement a First Nations and Métis recruitment and retention plan to help fill hard-to-recruit positions. The Authority's 2022-23 public performance plan included a goal of developing a First Nations and Métis recruitment and retention strategy by March 2023. The Authority asks staff to voluntarily self-declare whether they are First Nations or Métis. As a benchmark comparison, we compared the Authority's January 2022 staff voluntary self-declaration results to the 2019 target set by the Saskatchewan Human Rights Commission and found the Authority was only meeting the target in northeast Saskatchewan.

Although a First Nations and Métis recruitment and retention plan has not yet been developed, we found evidence of the Authority's commitment to creating a more diverse workforce. For example, the Authority had a targeted recruitment campaign for the rebuild of Prince Albert's Victoria Hospital. It also entered into a partnership with the Gabriel Dumont Institute in 2022 to provide additional access for First Nations and Métis learners to post-secondary seats. The Authority committed to recruiting up to 450 qualified Métis students from the institute from 2023 to 2028.

While the Authority has taken steps to create a more diverse workforce, lack of a First Nations and Métis recruitment and retention plan, including a diversity target, increases the risk of the Authority missing other potential opportunities to create a diverse workforce and to fill hard-to-recruit positions.

On page 154 we recommend the Saskatchewan Health Authority centralize its analysis of staff exit surveys to inform retention strategies for hard-to-recruit positions. Employee exit surveys help organizations assess the overall experience of staff during their employment and identify opportunities to improve retention and engagement. We found the Authority does not have a centralized process to conduct exit surveys with staff prior to their departure from the organization. It used a patchwork of different surveys in place prior to the creation of the amalgamated authority in December 2017. As a result, the Authority does not have a source of consistent data to allow it to analyze aggregate results from its exit surveys. 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.

In the final recommendation on page 158 we recommend the Saskatchewan Health Authority establish further measures to evaluate the success of its recruitment and retention activities for hard-to-recruit positions.

The Authority develops a public performance plan annually. Its 2022-23 performance plan included one target specifically related to the recruitment and retention of hard-to-recruit positions. By March 2023 the Authority expected to have no more than 5 per cent of permanent full- and part-time hard-to-recruit priority classification positions vacant for more than 90 days.

At March 2022 the Authority had 11 hard-to-recruit positions over the 5 per cent target of permanent full- and part-time hard-to-recruit priority classification positions vacant for more than 90 days, with some positions vacant for more than a year. Positions with the most significant chronic vacancies included respiratory therapists, speech-language pathologists, and combined lab and X-ray technicians.

We suggested other useful information the Authority could use to assess whether recruitment and retention strategies for hard-to-recruit positions are working, such as measuring employee retention rates, the average tenure of employees who leave the Authority, or the time to fill a position. Without sufficient quality measures to determine which recruitment and retention activities are working, it may be difficult for the Authority to effectively address vacancies in hard-to-recruit positions. Improved data analysis should help the Authority inform needed updates to and priorities for its recruitment and retention plans for hard-to-recruit positions.

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

**The Chair**: — Thanks so much for the focus of this chapter, the important recommendations. This is the first time that we've dealt with these. These are new recommendations for the Public Accounts. I'll turn it over to Deputy Minister Smith for remarks and then we'll open it up for questions.

**Ms. Smith**: — Thank you, Mr. Chair. Surrounding the recommendation to determine the most significant shortages of hard-to-recruit positions, the SHA continues to use a vacancy dashboard to identify vacancies at a point in time and a five-year projected forecast to determine any potential hot spots across the province. The SHA also monitors rural and remote communities experiencing disruption to determine where the SHA is seeing advances and where additional targeted work is required. Rural and remote incentives are available and utilized as recruitment tools to fill vacancies in these communities.

The SHA and Ministry of Health are collaborating on a refreshed five-year forecast that includes capital and service delivery expansions and takes into consideration the new supply based on increases to health care training seats announced in the winter of 2023. The new forecast will be adapted and used for ongoing workforce planning efforts across the Saskatchewan Health Authority. Further work is under way to build in functionality to support the ability to forecast at a more community service level.

To implement the recommendation to have targeted plans to address recruitment and retention, the SHA has implemented project plans for all hard-to-recruit classifications. Additionally the Saskatchewan Health Authority has aligned its '22 through to 2026 health human resources operational plan with the Government of Saskatchewan's health human resources action plan, which includes specific strategies and actions to address gaps in hard-to-recruit positions.

Some of these strategies include aggressive domestic and international recruitment; enhanced and modernized social media advertising; partnerships with our post-secondary educational institutions and community organizations; First Nations and Métis recruitment retention strategy; new and enhanced full-time equivalents in rural and remote communities to support stabilization; enhanced recruitment incentives; and retaining and growing our people by promoting employee well-being, continuous learning, and succession opportunities.

In regard to clinical placements being a successful recruitment strategy, the Saskatchewan Health Authority is developing a comprehensive plan that focuses on understanding the impacts of clinical placements through evaluation, trend monitoring, and detailed reporting to ensure effective management and optimization of the placement experiences.

Regarding the fourth recommendation, the Saskatchewan Health Authority is collaborating with the Ministry of Advanced Education to determine options for evaluating, tracking, and reporting success measures for recruiting to the Saskatchewan Health Authority from purchased out-of-province training seats.

Regarding the recommendation to implement a First Nations and Métis plan for hard-to-recruit positions, the SHA has developed a recruitment intention plan and is actively working on implementing this plan in alignment with its own operational plan around health human resources. Extensive engagement took place with Indigenous organizations, post-secondary institutions, some internal stakeholders within the Authority to inform the plan and to develop the recruitment and retention strategies that are contained within it.

Additionally the Saskatchewan Health Authority is committed to building a representative, diverse, inclusive, and culturally responsive workforce. Statements are added to all Saskatchewan Health Authority job postings that emphasize the collaborative efforts to improve the health and well-being of our population, our commitment to diversity and inclusion, and our dedication to implementing the Truth and Reconciliation's Calls to Action.

To implement the recommendations surrounding a centralized analysis of staff exit surveys, the Saskatchewan Health Authority has implemented a new exit survey tool and process to create consistent and centralized data to analyze for potential retention strategies related to hard-to-recruit positions. The Health Authority's ability to analyze the exit survey data will be based on the response rate of individuals leaving the organization, as it is a voluntary process.

To establish measures for evaluating recruitment and retention activity success, the SHA is monitoring and reporting monthly all chronic, permanent, full- and part-time hard-to-recruit vacancies with the trend over time, including any increases to FTEs [full-time equivalent]. This reporting is done by classification and location, and further identifies where gains are being made and where additional efforts are still required.

The Saskatchewan Health Authority is continuing its work to establish evaluation processes and metrics for hard-to-recruit strategies, including progress towards filling chronic vacancies. As part of evaluation efforts, the SHA has implemented QuickTapSurvey to assess recruitment and job fair event attendance and monitor the creation of health care in Saskatchewan profiles. The data collected supports informed decisions and ongoing recruitment efforts. And in partnership with the Saskatchewan Healthcare Recruitment Agency, further work will be done to identify additional outcome metrics related to new and expanded recruitment activities.

Detailed tracking and reporting have been implemented for specific classifications and initiatives. Examples include tracking metrics such as new graduation nurse hires, international educated nurse recruitment, and filling of vacancies related to new or enhanced rural and remote positions. By closely monitoring these metrics, we gain valuable insights that inform our strategies and enable us to make data-driven decisions to enhance our recruitment outcomes for the province. Thank you.

**The Chair**: — Thanks for the comments and the update that was there on the status update as well. We'll open up to committee members here for questions on chapter 12. Ms. Young.

**Ms. A. Young**: — Thank you. Thank you very much, Mr. Chair, and thank you for all the work undertaken on this very important file.

[13:30]

I see with recommendation no. 1 being partially implemented with the SHA and the ministry collaborating on a 5- and 10-year forecast, are you able to speak to facility locations identified that the SHA expects to have significant shortages of hard-to-recruit positions? And I suppose if you don't have that information immediately at hand, also happy to receive it at a later date.

**Mr. Northcott**: — Good afternoon. My name is Mike Northcott. I'm the chief human resources officer with the Saskatchewan Health Authority. So to answer your question, we have identified that the forecast does not include the facility location detail at this point in time. So that's work that we need to do with the ministry. And so that is work we will do, but right now it's in aggregate situation by profession.

**Ms. A. Young**: — Great. Thank you. So just to make sure I understand, you'd be able to identify, well we have a staff gap of cooks, for example, but we don't know if they're in Biggar or Kelvington or Regina specifically.

**Mr. Northcott**: — That's correct, in the actual forecast document. Now we do more detailed facility analysis that would dive into that, but the deliverable here is looking at the overall forecast and building that facility location level into that.

**Ms. A. Young**: — Perfect. And so hearing that's forward looking, in terms of the current state of data that you do have, you do have that currently by location. You are able to identify which positions are vacant in which locations around the province.

**Mr. Northcott**: — Okay. So as I said, we do have work to do around staffing levels at those individual sites. However, on our health career website you are able to . . . Every posting obviously has a location and you are able to sort. So that is a source of information there. But our forecast is by occupation at this point in time and so we have some more work to do to tie it to that facility location.

I would also highlight though that the capital project plans have staffing plans associated with them and identify we need X amount of RNs [registered nurse] and we need X amount of LPNs [licensed practical nurse], etc.

**Ms. A. Young**: — Thank you. So just to make sure I'm clear, currently the SHA is not able to identify which facility locations are currently experiencing shortages of hard-to-recruit positions except for going through the website and sorting by like positions available in — I don't know — Kindersley or Redvers. That would be the mechanism to identify that for the Health Authority?

**Mr. Northcott**: — Okay, so it is a combination of provincial information around the vacancies, but then also local level. So envision a manager or a director in a local geographic area. They're knowing their facility. They're knowing their staffing. They're working with their local HR [human resources] departments. The piece that we need to build is that bridge that connects the overall with the local.

**Ms. A. Young**: — Thank you. So in reading this chapter, part of what the Office of the Provincial Auditor speaks to are concerns that when the Saskatchewan Health Authority does not have the staff available to deliver needed health care services, disruptions can occur. You know, workforce shortages lead to service disruptions.

So just to be clear on my understanding, if workforce shortages are a concern for service disruptions, I'm hearing that the Saskatchewan Health Authority is not able to provide information in terms of which facility locations are currently experiencing shortages, staffing shortages leading to health care service disruptions. Is that accurate?

**Mr. Northcott**: — The answer to that is yes, we do know which facilities are in disruptions, and we work to fill those vacancies. Those are obviously really important to keep those facilities open.

[13:45]

**Ms. A. Young**: — Thank you. Is there a list of those facilities experiencing workforce shortages causing service disruptions that's available for the committee?

**Mr. Northcott**: — So we do monitor disruptions on a regular basis and it does change on a regular basis as well. So for instance, if we have a sick call, we may not have enough staff, so that may cause a disruption. So it's an evolving issue that we monitor closely.

**Ms. A. Young**: — Thank you for that answer. The question was about health care disruptions due to staff shortages, specifically for hard-to-recruit positions, not somebody calling in sick for an afternoon.

**Mr. Northcott**: — Okay. Okay, so as I said, there's many reasons for disruptions — lack of hard-to-recruit staff or vacancies. And that is one of those reasons. And that's why we've, with support of government obviously, been able to offer the $50,000 recruitment incentives to classifications that have been identified to help address that, as well as 250 new and enhanced full-time positions.

**Ms. A. Young**: — Thank you. Those are great and welcome government commitments. So maybe just I'll ask this question just one last time: so the SHA is unable to provide, on a facility

basis, information as to which facilities in the province of Saskatchewan are experiencing service disruptions due to workforce challenges or vacancy rates related to hard-to-recruit positions?

**Mr. Northcott**: — So the answer to that is yes, it can be provided and is provided. But it changes regularly, as you can imagine, with all the factors considered.

**Ms. A. Young**: — Thank you, I appreciate that undertaking. Looking at page 157 figure 12, and having heard the preliminary comments in regards to the chronic vacancy rates greater than 5 per cent, is this figure available for the past year as well? And are you able to offer any comments on whether the numbers are trending in what we would consider a positive direction?

**Mr. Northcott**: — Yes, we do track those numbers regularly. In order to do an apples-to-apples comparison we would need to run the numbers at the end of March to compare. But just to give you a flavour: when we look at our hard-to-recruit, our permanent part-time and full-time chronic vacancy rate has decreased from last January to this January by 1 per cent.

**Ms. A. Young**: — That's great. And I also see in the report that there is a June report that goes to senior management on the overall vacancy rates. And I don't think there's a particular interest in January being the specific point in time. Any point in time is fine.

[14:00]

**Mr. Northcott**: — Okay. I think the June version was the HHR [health human resources] operational plan, is I think what you're referring to there.

**Ms. A. Young**: — Yeah, I'm not sure. Just at the bottom of page 157 it notes . . .

**Mr. Northcott**: — Yeah, that's what that is, yeah.

**Ms. A. Young**: — Yeah. By no means an expert on the inner reporting that happens on all of this stuff. Just working with what we've got, so I appreciate that. Thank you.

You mentioned the rural and remote recruitment incentive. Maybe I'll just kind of shoehorn a couple of questions in here in recognition of everybody's time. I'm interested that the SHA has seen an improvement since the announcement of this incentive in hiring those positions. And I'm interested in how many full-time employees of each profession have accessed the rural and remote recruitment incentive and if you have information as to where those people are, you know, how many FTEs in what positions. And again, if that information isn't something you have at your fingertips, happy to receive it at a later date.

**Mr. Northcott**: — So as of February 8th, 253 people have received this, and we can provide you a breakdown by location and classification.

**Ms. A. Young**: — Thank you. Thank you very much. I appreciate it. Also really glad to see the SHA is conducting exit interview surveys to inform retention strategies. Wish we had more time. I'd like to ask you like 30 different questions on retention specifically.

I'm wondering if you are able to share some information and specific examples with the committee about the reporting and some of the data and trends that you're seeing from these interviews that you've collected so far?

**Mr. Northcott**: — So the exit survey goes to staff who exit, once a month, and we started this in the fall. So we've had one cycle of this so I can't give you trends based on one cycle. Yeah, and then we'll be doing quarterly analysis.

**Ms. A. Young**: — Perfect. Hearing, of course, you can't give a trend with one cycle, is there any comment you can offer on what I suppose would be the start of your baseline data then?

**Mr. Northcott**: — Not at this time as we're just working through it.

**Ms. A. Young**: — Thank you. Can you clarify what the distinctions are? I don't know if it'd be from a governance perspective, but looking at the Healthcare Recruitment Agency, and how SHA and your team, priorities of the Healthcare Recruitment Agency — how all of these fit together from a strategic and governance perspective. And essentially, like who's steering the ship and how are you all working together to address the concerns identified in this chapter?

**Ms. Smith**: — Thanks for the question. I will maybe just start with this piece just to try to help kind of connect the dots to your point around like how does this work. So we've obviously got, you know, each of the organizations that are a part of health human resources as a whole. And with the creation of the Healthcare Recruitment Agency, again the intent there was to really bring some focus to the priority and the importance of health human resources in the province and to also be able to provide that ability for the recruitment agency to really focus on the recruitment needs of the province as a whole.

And so how it's working, I would describe how it's working in practice is just at the very highest level. I would say that you've got the ministry that works obviously very closely with the agency, with the Health Authority, with the Cancer Agency. When I think about the health care employers of the province, you know, our two primaries would be the Cancer Agency and the Health Authority. And so it's this combination, there would be information sharing, there would be sort of working through what are their priorities as a whole.

What the agency's been doing is it's been going and meeting with a whole range of stakeholders, including the employers. And a part of, you know, a part of those conversations are to enable the SHA to really reinforce with the recruitment agency what are the priority positions that are needed and how quickly do they need them, and really try to sort of lay out what those priority areas are. And similarly for Cancer Agency.

And then it will be the recruitment agency's responsibility to be able to go and try to identify sort of individuals that might be ready for employment for those particular positions. So then they could be going to recruitment fairs. They do a lot of work with the academic institutions to identify students that would be potential employees of those agencies.

And so I guess how I would sort of sum it up is it's very collaborative. All of the partners need to be working very closely together to identify what the priorities are and the actions that we're going to take.

The other piece that I would add is that we're also really taking a broad approach in the sense of you've got the Ministry of Health involved, connecting really closely with our partner ministries as well like Advanced Education, Immigration and Career Training, Trade and economic development. And again the reason for that is, again because of the priority of this area, we all need to be working really, really closely together.

So in terms of just the agency itself, again it's been under way for the last number of months. And sort of the expectation there is that they're working really closely with everyone to really understand what the needs are and then be able to go and recruit for those positions.

**Ms. A. Young**: — Thank you very much. I don't want to belabour this point too much, but is there a formal governance structure in terms of how those pieces all fit together?

**Mr. Northcott**: — So we do have a health human resources partnership table, and Erin Brady, who's the CEO of the recruitment agency, sits at that table. So that includes members of the Ministry of Health, myself from the SHA, Cancer Agency reps, and reps from other ministries as well and organizations, including Cancer Agency.

**Ms. A. Young**: — Thank you. Thank you very much. I think, recognizing the time, I will leave it here for now. When do we expect this back to committee?

**The Chair**: — Maybe I'll ask the auditor just to comment on the process now of the follow-up on this front, and then her report back to us.

**Ms. Clemett**: — A fair amount of these recommendations I would say we know are complex and challenging. So I definitely think that this will take potentially, you know, the five years for implementation. But we do have plans to go back in 2025 to evaluate the status of the recommendations at the time with our report coming out in basically our volume 2, 2025.

So then obviously, usually the Public Accounts Committee wouldn't see that chapter for about a year's time, so you're probably 2026, just so you are aware. So a couple years from now.

**The Chair**: — Any further questions, folks, with respect to this chapter? Certainly very important work that's being undertaken on this front and being committed to, and I want to thank those that are involved in that work.

With respect to the recommendations before us, I'd welcome a motion that we concur and note compliance with respect to 2 and 6. Moved by Ms. Lambert. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's carried. I would welcome a motion that we conclude and note progress with respect to recommendations 1, 3, 4, 5, and 7. Moved by Mr. Goudy. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's carried as well. We'll keep moving along here and turn our attention to chapter 18, and I'll turn it back over to the Provincial Auditor and her office.

**Mr. Wandy**: — Thank you, Mr. Chair. The Saskatchewan Health Authority is responsible for delivering accessible and responsive ground ambulance services to the people of Saskatchewan. Accessible and responsive ambulance services can be challenging because of the geographic spread and remoteness of some communities in rural Saskatchewan, including Swift Current and surrounding area.

Chapter 18 of our 2022 report volume 1 reports the results of our second follow-up of management's actions on the six recommendations we made in our 2016 audit about the Authority's processes to deliver accessible and responsive ambulance services in southwest Saskatchewan.

[14:15]

By December 2021 we found the Authority implemented five recommendations. The Authority improved its monitoring of ambulance operators' compliance with expected ambulance response times and began receiving regular reporting for all ambulance services. It also worked with the Ministry of Health to develop a performance-based contract template for the provision of ambulance services, and signed 28 new contracts for 32 privately owned ground ambulance services in Saskatchewan, including four out of five in Swift Current and surrounding area. Finally the Authority and the ministry conducted a sufficient analysis of supply and demand for ground ambulance services across the province, considering input from ambulance operators.

We found the Authority had not yet implemented the last remaining recommendation on page 199, where we recommended the Saskatchewan Health Authority report to senior management, the board, and the public, actual results against key measures to assess the success of its ground ambulance services at least annually. We found once the Authority signs performance-based contracts with all 53 privately owned ambulance service providers in the province and implements a new dispatch IT system, it will have better information about service quality.

Collecting better performance information will allow the Authority to regularly assess the success of its ground ambulance services and publicly report on ambulance response times in Swift Current and surrounding area.

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

**The Chair**: — Okay. Thank you very much for the focus, the very important focus on this front around ground ambulance. I'll turn it over to the deputy minister for brief remarks and then we'll get into the questioning.

**Ms. Smith**: — Thank you, Mr. Chair. The Provincial Auditor noted that the recommendation surrounding assessing for optimal distribution of ambulance services has been implemented in its

2022 report volume 1. The Saskatchewan Health Authority and the Ministry of Health conduct analysis of the supply and demand for ground ambulance services across the province, considering input from ambulance operators. In addition, the Ministry of Health reviews ground ambulance services annually.

The Provincial Auditor noted that the recommendations for considering updates to the legislation and updating contracts surrounding the provision of ground ambulance services have been implemented in its 2022 report volume 1. The Ministry of Health considered contract management best practices when it directed the Saskatchewan Health Authority to develop a performance-based contract template for contracted ground ambulance service providers, instead of making changes to *The Ambulance Act*. In Swift Current and surrounding area, the Saskatchewan Health Authority has transitioned contracts within the five privately owned ground ambulance operators to the new format.

The Provincial Auditor noted that the recommendations regarding monitoring response times and following its policy to obtain incident reports for ground ambulance services have been implemented in its 2022 report volume 1. And since May of 2019, ambulance services in emergency medical services south zone are required to provide their area manager a monthly statistical report that explains the reasons specific calls did not meet response times. The area manager also receives a monthly response time compliance report used to confirm the monthly statistical reports provided by the services.

In regards to the recommendation for reporting to senior management, the board, and the public, the SHA has included metrics in the performance-based agreements with contracted ground ambulance service providers, and reporting against performance metrics is expected to be implemented with the new computer-aided dispatch system, otherwise known as CAD. The CAD went live on November 27th, 2023 with the reporting system to be developed within the next six months after that. Thank you.

**The Chair**: — Thank you for the remarks and the work on these fronts. I'd open it up now to committee members for questions. Ms. Young.

**Ms. A. Young**: — Thank you very much. I recognize the majority of these recommendations have been implemented, and obviously ambulance services are an essential and critical component of the provincial health care system and especially when we look at more rural and remote areas of the province in terms of accessing potentially life-saving care. But in looking at a number of these recommendations, obviously there's a lot in the news and in the public awareness right now around concerns for wait times for ambulances even within major urban centres.

So with that preamble, looking at the recommendations, even those that have been implemented, recognizing they're seeking to address reporting standards from service providers to the Ministry of Health, they are around . . . A number of them focus on instances such as like when ground ambulance response times do not meet targets. And given certainly what's out there in the public imagination and the news right now, I'm wondering if you could speak on some trends that you're seeing with some of these key deliverables such as response times, such as incident reports specific to the Southwest. But, I don't know, perhaps I'm assuming it's the same across the province. So if you're able to speak provincially as well.

**Mr. Witt**: — Thank you. My name is Bryan Witt. I'm the vice-president, provincial clinical and support services. So your question around the provincial trends, I would say provincially we're continually monitoring EMS [emergency medical services] services across the province, and one of the big things that we see and identify is a variation in those response times in communities across the province. And so working with our paramedic service providers and the SHA, we meet very regularly in analyzing the data that we have in terms of those response times.

And through those meetings, we work with those partners in identifying what potential future investments we should be making and working with the ministry in future budget cycles, working in terms of deploying those investments, to try to level out and ensure that we're reducing that variation in the community response times.

**Ms. A. Young**: — Thank you. Thank you for that response. Hearing that you're continually monitoring, and seeing that performance-based contracts were implemented in I believe it was fall 2022, if my notes are accurate, the response time of 30 minutes is the current target for ambulance services. And now having performance-based contracts, is that target, is that standard of 30 minutes response time, being met? And I suppose, what percentage of the time is it met? And then by way of follow-up, if it is not being met, with performance-based contracts, what are the outcomes for service providers?

[14:30]

**Mr. Witt**: — Thank you for the question there. So with the performance-based contracts, the target still remains at that 30 minutes. Within the contracts we work with the providers and when we identify . . . And again we meet with them quite regularly, weekly and monthly. We have a number of different opportunities to meet with the service providers. When we identify that they aren't meeting those 30-minute targets, we actually will work with them on trying to understand what are the reasons behind that. You know, were they on another call? Was there a breakdown with equipment? You know, what are those reasons? And there's quite a few that could be in play.

And again we work with each of those contractors to identify what are those barriers when they didn't, and what are the opportunities for us to work with them on ensuring that they can maintain those 30-minute targets. And what are the opportunities that we need in terms of different maybe investments or working with other providers to help support that particular provider.

**Ms. A. Young**: — Thank you very much. Just to restate it, my question was specifically around whether or not the 30-minute target was met, what percentage of the time it was met, and how many calls are received in which that target is actually achieved. I see in the information provided by the Office of the Provincial Auditor it appears to indicate that operators consistently provide that information. I believe it also notes that it's provided monthly.

If that information isn't readily available for the committee

today, also happy to receive it at a later date. But again, specifically the 30-minute time: how often that is achieved, how often it is not, and for what number of calls.

**Mr. Witt**: — We don't have that information today, but we will be able to follow up with the committee and get that to you right away.

**Ms. A. Young**: — Thank you very much. I appreciate it.

**The Chair**: — I'll just take a second. Thank you. Thanks for that. And so you're collecting information on this front; you're getting those reports. I appreciate the undertaking. If you could just provide that information in a fulsome way with — you know, as the member has asked those questions — that information back to us. Is it within a four-week period, is that reasonable for you to supply that back to this committee?

**Mr. Witt**: — Yes.

**The Chair**: — Thank you very much.

**Ms. A. Young**: — So I see that performance metrics have been included in the updating contracts with ground ambulance service providers and that, theoretically, reporting against those metrics is to be implemented with a new computer-aided dispatch system. Is that system functional right now, up and running?

**Mr. Witt**: — Yes. It went live November 27th.

**Ms. A. Young**: — Okay. Wow, recent. That's great. And what was the cost for the development of that system?

**Mr. Witt**: — All right. The initial cost was $1.4 million to launch, with ongoing maintenance and licensing fees initially around 600,000 a year, but over three years will go down to around 500,000. And this is hosted in-house by the Sask Public Safety Agency as well too.

**Ms. A. Young**: — Thank you very much. And now looking at the outstanding recommendation no. 6 in the auditor's report, it notes that neither the board, senior management, nor the public received reports on key measures related to the delivery of ground ambulance services. However in the status update it notes that performance metrics are included in the updated contracts with ground ambulance service providers. Is there any intent in implementing the recommendation as written, with reports going to senior management, the board, and the public?

**Mr. Witt**: — All right, thank you for the question. So I see this as a bit of an equation in a way. So we have the performance-based contracts in place. Now what we have is the CAD system that's in place that we rolled out in November. Together that's going to work with the data analytics within the CAD and the performance-based metrics within the contracts to help us generate those reports.

And so we've committed that by six months after the rollout of the CAD system here that we'll start to be able to generate the reports that we need. And we're going to be looking at other reports that are used across the country for benchmarking to make sure that we're sort of generating reports that make sense. And then we fully intend to create these reports to share with our board and to work with them and their senior leaders as well too within the SHA.

It might take a few iterations of the report to get something that's meaningful. There's a lot of analytics within the CAD system now, our new system, so it's going to be working through what's of value for us and the public and in our board and our senior leadership, and how do we generate that into a report that's meaningful.

**Ms. A. Young**: — Thank you. So November 27th, 2023, was when the CAD went live? So based on your last comments, anticipated in May of 2024, maybe May, June is when the first report . . .

**Mr. Witt**: — Yeah, exactly. May, June is when we'll start to be able to generate those reports. And then again, it might take a few iterations to get something that is truly valuable for us.

**Ms. A. Young**: — Thank you. And I heard in your comments that there is the intent to report to the board and to senior management. Is there the intent to report to the public?

**Mr. Witt**: — I think that's going to be something that we'll work with the board on. And I don't know if I'll be able to answer that; we'll have to work with the board on that one.

**Ms. A. Young**: — Thank you. And can you remind me, who's the board?

**Mr. Witt**: — Oh, the SHA board.

**Ms. A. Young**: — The SHA board, yeah. So it will be the board of the Saskatchewan Health Authority that's deciding on whether or not there's publicly available information in regards to ambulance service delivery?

**Mr. Witt**: — Thanks. I can add some clarity. So we'll work with the board on the reporting and the formatting, what that looks like, and then we'll work with the SHA and the Ministry of Health. We'll take that reporting format and we'll work together on how we format in terms of that public reporting as well too, as there's a number of different ways that we can report to the public. So this will be reported to the public. It's just really refining what that report looks like and ensuring that it's appropriate and meaningful.

**Ms. A. Young**: — Thank you very much. And last question from me, it's also noted in the chapter that management committed to creating an annual provincial emergency medical services report with trends and analysis. Does this report exist today? If not, when is it anticipated? And lastly, is this a report that's intended to be public-facing?

**Mr. Witt**: — That report, it hasn't been created yet, but the intent is to use the CAD system to generate that report. And then really I think we need to generate it first and see what it tells us and to figure out how we essentially use that report.

But again there's a commitment to do that annually, but we haven't generated it yet so we just don't even know what it even looks like yet. That's going to be our work this year.

**Ms. A. Young**: — Great. Thank you. No further questions, Mr. Chair.

**The Chair**: — Thanks so much. And just to confirm, all the information around the 30-minute target, that'll be provided back to this committee along with more fulsome information around some of the information that's contained in that report. Is that correct? Thanks very much.

Just a comment. We appreciate that so many of these recommendations are actually super substantive, that there's tons of different folks that are working on these recommendations. On the actual status updates, just chatting with some of the members around the table, one thing that can really aid us coming in to this committee is just having a bit more substance and detail to the components behind the actions.

We could share some of the other examples at some point around what we receive from some of the other entities, because what it allows us to have is more information, and then it allows you to sort of drill down where you might feel that there's certain gaps.

So just looking at some of the action statements here. They look good. We know there's substantive work. We know there's a lot of work that's gone into this. But if some of those pieces could just be broken out, it really allows us to sort of see what's already happened and what's being collected, or you know, what's being measured, and then where there might be some gaps for us to focus some of our questions. When the statement's a little bit broader or a bit more vague, it lends itself to, you know, a lot more scrutiny or questions, if you will. So just something that I think can aid this committee.

And I know when we come in here it's not our goal to have folks in here longer than they need to be or anything. We recognize how valuable all of your time is, and we try to, you know, simply get to the point of where there's gaps or assess for understanding. So a little more information in those status updates is something that might be really helpful into the future, recognizing all the good work that's going on.

So any further questions on this chapter? Not seeing any, we will move along now to chapter 20.

**Mr. Wandy**: — Okay thank you, Mr. Chair. The Saskatchewan Health Authority is responsible for establishing and enforcing policies and procedures so long-term care residents get the right medication at the right dosage when required. Chapter 20 of our 2022 report volume 1 reports the results of our third follow-up of management's actions on the two remaining recommendations we made in our 2014 audit about the Authority's processes to manage medication plans for residents in long-term care facilities located in Kindersley and surrounding area.

By January 2022 the Authority fully implemented the two remaining recommendations. The Authority implemented a process to audit whether long-term care facilities adhere to policies requiring informed consent from residents or their designated decision makers for the use of medication as a restraint or for changes in high-risk medications.

[15:00]

This process contributed toward the Authority improving its documentation of informed consent. We found 86 per cent of client files we tested included documentation of consent when using medication as a chemical restraint and 73 per cent of the files included documentation of consent for changes in high-risk medications. We found the Authority's audit results for three facilities we visited improved between April and December 2021, noting a 40 per cent improvement associated for high-risk medications and a 20 per cent improvement for medication used as a chemical restraint.

Having informed consent reduces the risk a long-term care resident or their designated decision maker is unaware of a medication's effects and the influence it may have on a resident's quality of life. Implementation of a monitoring process such as periodic audits is an effective tool to promote staff compliance with informed consent requirements.

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

**The Chair**: — Well thanks so much for this chapter and the follow-up on this front and the work that's been taken on by the ministry. I'll turn it over to DM Smith for some comments and then we'll open it up questions.

**Ms. Smith**: — Thank you. The Provincial Auditor had noted the Saskatchewan Health Authority had implemented their recommendation to follow the policy to obtain informed written consent from long-term care residents or their designated decision makers prior to using medications as a restraint. The Health Authority implemented a review process to ensure facilities are complying with policies and obtained informed written consent as required.

Surrounding the recommendation to have a policy requiring informed written consent for changes in high-risk medications, the Provincial Auditor has also noted that this was implemented in its 2022 report volume 1. Thank you.

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

**Ms. A. Young**: — Thank you for very much. Recognizing these recommendations are implemented, I just have two quick questions on — I assume two quick questions — on this chapter.

Looking at the auditor's December 2023 report, which I believe found that 13 of 15 contracted special care homes in Saskatoon had more than 27.5 per cent of residents using antipsychotic drugs without a diagnosis of psychosis, I'm wondering if the SHA has a formal policy on antipsychotic medication for non-diagnosed residents.

**Ms. Schwan**: — So I'm Brenda Schwan, and I'm the vice-president for integrated rural health. So to answer your question, so we do have the provincial special care home guidelines, and part of that we also have the quarterly long-term care indicators. And there is triggers, so if you have antipsychotics without a diagnosis, they would be triggered on that. And if you are above that target then you need to submit a corrective action plan.

**Ms. A. Young**: — Thank you. And I see that the auditor found 86 per cent of client files included documentation of consent when a restraint medication was used and 73 per cent included

documentation of consent for changing high-risk medications, understanding that these numbers are from, I think, 2019. If possible, and I appreciate they may not be at your fingertips today, but if it's possible for the committee to get those numbers updated for the last four years, I suppose then, 2019 to date — whenever the most recent numbers would be.

**Ms. Schwan**: — So those numbers that you had quoted were on a random audit so I don't have like over the last four years. What I can say though is we do medication reviews every quarter within the facility, and part of that medication review is the pharmacy printing us a print of all the medications that they're on. The community pharmacist may or may not attend along with the nurse and the physician. And they would go through and, you know, note what medications a resident would be on. And they would also look for that consent. So those quarterly reviews are happening.

**Ms. A. Young**: — But it's not something you like report out on like a quarterly basis or annual basis.

**Ms. Schwan**: — No.

**Ms. A. Young**: — Okay, thank you. I understand.

**Ms. Schwan**: — Yes.

**Ms. A. Young**: — Mr. Chair, I have no further questions.

**The Chair**: — Any further questions from committee members on chapter 20? This is the 2022 report volume 1. Not seeing any, I'd welcome a motion to conclude consideration of this chapter. Moved by Mr. Fiaz. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's carried. Ms. Young? You're good? Okay. We'll move right along to the next chapter 20.

**Ms. A. Young**: — I could use a break. Sorry.

**The Chair**: — Oh, sorry. So just one moment. We'll take just a couple minutes for a recess here.

[The committee recessed for a period of time.]

**The Chair**: — Okay, folks. We'll keep moving here and we're going to turn our attention to chapter 20 from the 2023 report volume 1.

**Mr. Wandy**: — Thank you, Mr. Chair. The Saskatchewan Health Authority is responsible for the planning, organization, delivery, and evaluation of the health services it provides. One of the public health and safety issues Saskatchewan faces is suicide. In Saskatchewan approximately 195 people die by suicide each year. In northern Saskatchewan suicide is the leading cause of death for people aged 10 to 49.

Chapter 20 of our 2023 report volume 1 reports the results of our first follow-up of management's actions on the eight recommendations we made in our 2019 audit about the Authority's processes to treat patients at risk of suicide in northwest Saskatchewan. By November 2022 we found the Authority fully implemented two recommendations and partially implemented the remaining six recommendations.

The Authority implemented the two recommendations on pages 200 and 201 where we recommended the Saskatchewan Health Authority conduct risk-based file audits of patients at risk of suicide in northwest Saskatchewan and periodically inspect the safety of its facilities in northwest Saskatchewan providing services to patients at risk of suicide.

We found the Authority conducts risk-based file audits to determine whether staff appropriately completed suicide risk assessments and safety plans for the patients and also periodically inspects the safety of its facilities in northwest Saskatchewan providing services to patients at risk of suicide.

We found the Authority conducts risk-based file audits to determine whether staff appropriately completed suicide risk assessments and safety plans for the patients and also periodically inspects the safety of the Battlefords Union Hospital where it provides services to those patients.

Completing risk-based audits of patient files helps the Authority identify areas needing improvement. It also helps reduce the risk that staff are not providing adequate care to patients at risk of suicide. Additionally, preparing rooms to be safe for patient use and periodically inspecting facilities providing services to patients at risk of suicide decreases the risk of a patient committing self-harm while in the Authority's care.

We found the Authority partially implemented the recommendation on page 193 where we recommended the Saskatchewan Health Authority work with others, for example the Ministry of Health, to analyze key data about rates and prevalence of suicide attempts to rationalize services made available to patients at risk of suicide.

Good practice suggests focusing on certain key measures like suicide rates, hospitalization rates for self-injury, and emergency department rates for self-inflicted injury to assess the services provided to patients at risk of suicide.

We found that while the Authority can request suicide data from the Saskatchewan Coroners Service, it only analyzed data for communities in the far northwest area of the province. It did not do so for other communities in northwest Saskatchewan. Additionally, the Authority indicated it reviews data collected from the Canadian Institute for Health Information on reasons for self-harm hospitalizations, but could not provide evidence of how it used this information to support further analysis or decision making.

Finally, while the Authority is able to produce a listing of individuals admitted to emergency departments with a diagnosis of suicidal thoughts, self-harm, or attempted suicide, we found it does not produce this listing for its own analysis on a periodic basis. Our review of such a listing covering an eight-month period found the Authority admitted at least 120 individuals to emergency departments in Saskatchewan's Northwest with a diagnosis of suicidal thoughts, self-harm, or attempted suicide.

Reviewing trends and performing analysis of key data can inform the planning and implementation of treatment programs. It can

also help the Authority determine whether it gives individuals at risk of suicide in northwest Saskatchewan sufficient access to services and whether the programs make a difference.

We found the Authority partially implemented the recommendation on page 196 where we recommended the Saskatchewan Health Authority give suitable training to staff located in northwest Saskatchewan caring for patients at risk of suicide.

In June 2021 the Authority implemented a work standard outlining the minimum mandatory orientation and training for staff caring for patients at risk of suicide. For example, the Authority requires staff working with mental health and addictions patients to complete annual training on identifying suicide risks and completing assessment forms and safety plans, augmented with on-the-job training. However we found the Authority does not have a system or process to track training completed by staff.

Not centrally tracking staff training increases the risk of staff, who work with patients at risk of suicide, missing key training courses. Not providing consistent training to staff increases the risk that staff may not follow the practices the Authority expects and may provide patients with inconsistent care.

We found the Authority partially implemented the recommendation on page 197 where we recommended the Saskatchewan Health Authority follow its established protocols to provide psychiatric consultations to patients accessing emergency departments in northwest Saskatchewan who are at risk of suicide.

The Authority requires staff to screen patients admitted to emergency departments for risk of suicide using a standard suicide-screening assessment. If staff determine the patient is at high risk of suicide, the Authority expects staff to consult with a psychiatrist or senior clinician prior to patient discharge. We tested 30 files of patients admitted to emergency departments for suicidal thoughts, self-harm, or attempted suicide and found three instances where the Authority did not screen patients to determine their suicide risk levels. As such, we were unable to determine these patients' need for psychiatric consultations.

At the time of our testing, these patients had yet to access mental health and addictions services in northwest Saskatchewan. Emergency department staff inconsistently following the Authority's protocols to screen patients for suicide and consulting with psychiatrists prior to patient discharge, where necessary, increases the risk of those patients not receiving needed support and treatment.

We found the Authority partially implemented the recommendation on page 197 where we recommended the Saskatchewan Health Authority address barriers to using videoconferencing to provide psychiatric services to communities in northwest Saskatchewan.

We found the Authority took steps to address patient barriers in using videoconferencing to provide psychiatric services in northwest Saskatchewan. It implemented a new videoconferencing system in 2020 to provide more flexibility for patients and clinicians so they can access their appointments from anywhere through an application installed on a computer or mobile device.

However we found patients continued to poorly utilize videoconferencing to access psychiatric services. The no-show rate for videoconferencing appointments for northwest Saskatchewan was 36 per cent between January and November 2022. While this is a slight improvement from the no-show rate of at least 50 per cent in 2019, we found the Authority does not track or assess why patients are not showing up for their videoconferencing appointments. Not determining reasons for the poor use of videoconferencing or psychiatric services in northwest Saskatchewan reduces the Authority's opportunities to identify and address barriers.

We found the Authority partially implemented the recommendation on page 198, where we recommended the Saskatchewan Health Authority analyze reasons patients at risk of suicide miss appointments for mental health out-patient services, to help address barriers. In 2019 the Authority implemented a work standard, providing clear guidance to staff for contacting patients who missed their scheduled appointments.

The Authority requires staff to attempt contacting the patient within one hour of missing their appointment, and again the next day if the first attempt was unsuccessful. Staff must also complete a form documenting the dates and times staff attempted to contact the patient, along with the patient's reason for not attending the appointment.

We tested 16 scheduled appointments and found the Authority did not attempt to contact four patients and complete the required form to document reasons why patients missed their appointments. In addition, while the Authority began compiling data for the reasons why patients missed their scheduled appointments in 2022, we found they had yet to complete an assessment of the data to identify barriers for why patients do not attend scheduled appointments. Insufficiently analyzing reasons for missed appointments for out-patient services in northwest Saskatchewan reduces the Authority's opportunities to identify and help patients overcome barriers to attending appointments.

Finally we found the Authority partially implemented the recommendation on page 199, where we recommended the Saskatchewan Health Authority follow up with patients who attempted suicide discharged from emergency departments in northwest Saskatchewan to encourage treatment where needed. Upon discharge, emergency departments refer patients who attempted suicide to out-patient services, including addictions counselling or psychiatric care, or to in-patient services.

The Authority expects mental health and addictions staff to follow up with patients needing out-patient services the next business day and determine further referrals or follow-up appointments. We tested 30 patient files and found the Authority referred all patients to out-patient services but did not follow up with five patients timely, or not at all, following their discharge. Following up with patients after discharge decreases the risk of patients not receiving the care they need. Proactive follow-up promotes continuity of care and continues the assessment and management of suicide risk.

[15:30]

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

**The Chair**: — All right. Thank you very much for the follow-up on this chapter and the important work in this chapter. I'll turn it over to Deputy Minister Smith for remarks and we'll open it up for questions.

**Ms. Smith**: — Thank you. Regarding the recommendation for the Health Authority to collaborate with others and analyze key data for suicide rates and prevalence, the Health Authority has done so by gathering and analyzing key data from broader sources across northwest Saskatchewan, including the health authorities, emergency departments, mental health services, the Ministry of Health, and the Saskatchewan coroners office.

In response to the findings of the data we analyzed, mental health and addictions services in northwest Saskatchewan had invigorated partnerships with families, the school system, and other caregivers to address the increased utilization of emergency room services by children and youth across the greater Northwest.

To implement the recommendation to provide suitable training to staff in the Northwest the Authority has provided up-to-date suicide risk assessment intervention training for all new and existing mental health and addictions staff in the Northwest who were previously not trained.

A manual tracking system has been developed within the mental health and addictions Northwest, monitored by program managers for all staff under their supervision. Mental health and addictions services continues to work in partnership with digital health analytics to develop an automated system of tracking required areas of training.

Ongoing work continues within the Ministry of Health and other partners to develop a full standardized menu of suicide risk assessment, intervention training options that will be tailored to meet the needs of all staff, including those working in other areas of care such as primary health care, emergency rooms, and community partners and agencies.

Surrounding the recommendation for the Health Authority to follow established protocols to provide psychiatric consultations, two work standards have been jointly developed by the mental health and addictions services working with the leadership of the emergency departments and primary health care in the greater Northwest. The work standards which have been implemented stipulate how all patients at risk of suicide are to be screened and the process to access psychiatric consults in emergency departments during normal hours of operation as well as in the after hours.

Additionally the process for referring from emergency departments to psychiatry for consultation for patients at high risk of suicide has been enhanced. The intake system in the greater Northwest serves to receive referrals from emergency departments and connects patients at risk of suicide to psychiatry for consultations as need be.

The two work standards mentioned above also provided for emergency room physicians and clinicians to access direct and immediate consultations to the on-call psychiatrist or to the SHA's System Flow for 24-hour on-call psychiatric consultation.

To address the recommendations surrounding barriers to videoconferencing to provide psychiatric services, telehealth and videoconferencing as a service package was reviewed by mental health and addictions services management, telehealth/videoconferencing facilitators, psychiatrists, and office administrative staff.

This collaboration resulted in a work standard, orientation form, and a no-show form being jointly developed to stipulate service flow to patients. Missed appointments for videoconferencing are now included in the monitoring of reasons for missed appointments. This information will serve to rationalize access and delivery processes on an ongoing basis.

At the time of the Provincial Auditor's previous visit, data surrounding missed appointments was just beginning to be gathered for analysis. Clinicians have been reminded of the importance of following the developed work standard. The process for no-show data collection and analysis has been created and implemented.

Data has since been gathered with consideration given to the geographic areas of the remote far North versus the large urban areas. Barriers related to remoteness, demographics, personal resource differentials, and other social factors are being identified and addressed. Standardized processes to gather and analyze data, so as to establish reasons clients miss appointments, have been created and deployed in the greater Northwest.

To address the recommendation surrounding follow-up with discharged patients to encourage treatment, two work standards have been developed. All service centres in northwest Saskatchewan have implemented the process of follow-up with patients at risk of suicide after they are discharged from the emergency department. There is currently a standard process for northwest Saskatchewan for following up with patients at risk of suicide.

The Provincial Auditor noted in its 2023 report volume 1 that the recommendation to conduct risk-based file audits of patients has been implemented. The SHA has implemented monthly suicide file auditing as a standard clinical procedure in the greater Northwest. Additionally mental health and addictions service managers do follow up on audit outcomes that do not meet full compliance and educate clinicians on how to achieve set standards.

The Provincial Auditor noted in its 2023 report volume 1 that the recommendation for periodically inspecting the safety of its facilities providing services to patients at risk of suicide has been implemented.

Primary health care executive directors in northwest Saskatchewan are committed to ensuring annual inspections are completed and results received in a timely manner beginning in March of 2020. This process is occurring as committed. Ongoing consultations, on-site meetings, and site visits in facilities will occur as often as reasonably possible. And managers and staff of in-patient units, particularly in-patient mental health units where patients with higher risk of suicide are admitted, are regularly monitoring their units for safety risks. Thank you.

**The Chair**: — Thanks so much for the remarks here and the work on these fronts, incredibly important work. I'll open it to committee members now who have questions. Ms. Young.

**Ms. A. Young**: — Thank you. Thank you very much, Mr. Chair. Hoping to go through these relatively sequentially and appreciating that some of this work is . . . At the outset, Deputy Minister, you spoke about key data being gathered in terms of recommendation no. 1 and the analysis that's going on and how that's invigorating partnerships, I believe were your words.

I'm wondering if you can provide the committee more information and more specifics on what that actually means and how the data that's being collected is being used to inform and impact any policy decisions and delivery of services available in the Northwest.

**Mr. Miller**: — Good afternoon. I'm Derek Miller. I'm the chief operating officer with the SHA, and happy to be here this afternoon. I'll be answering a few of the questions for this particular chapter. First of all, I'd like to say that this is an area of focus for the SHA, a priority, and we have been working hard to implement the auditor's recommendations and make improvements in this area.

First of all, in terms of the data you asked about, you know, what kinds of things are we looking at? We have a quantitative approach where we're looking at historical data around suicide, people identified for suicide risk, as well as data that we gather through the coroner's office and the Ministry of Health to help form a picture and an understanding.

We also gather qualitative data, like through our clinical teams in terms of what they're hearing and seeing as they do their work and our leaders that are leading our departments in the Northwest, and we use that to make a number of improvements in how we're working. And part of it is, as we mentioned, on the partnerships and how we're partnered, for example, with schools on improving access to mental health services.

We also have the Roots of Hope project. It's being run out of Buffalo Narrows, and it's really a community-based approach to suicide prevention. So really looking on the front side to try to promote prevention of suicide.

We had made a number of decisions around resource allocation within the SHA, both new resources as well as redeploying existing mental health staff into certain areas where we can better address mental health needs. For example, we've added mental health assessors and counsellors in La Loche, both in the emergency department as well as in primary health care. We have a coordinator that's leading the Roots of Hope work in Buffalo Narrows. As well, we've introduced primary health care counsellors in Ile-a-la-Crosse.

[15:45]

We have a regional community nurse that's focused on child and youth mental health services. As well, within the emergency departments in Lloydminster and Battlefords Union Hospital, we have reassigned counsellors as well as psychiatric nurses to work within the emergency departments to assist with the assessment processes and support the emergency room physician in clinical decision making as well as the referrals to psychiatry.

And then lastly we have identified a resource that has been focused exclusively on the recommendations that came out of the auditor's report to help us progress them, as we believe this is of critical importance for us.

**Ms. A. Young**: — Thank you. Thank you very much. In the introductory comments I believe it was noted that, at the time of writing, the SHA was using data — forgive me; please correct me if I'm misstating — exclusively from the far Northwest of the Northwest as opposed to all of northwestern Saskatchewan. I'm wondering if the data collection has been expanded.

**Mr. Miller**: — So in reference to your question about expanding the use of data from the far Northwest to include all of the Northwest, we have done that. And it's reflected in some of the decisions that have been made in terms of resource allocation, deploying additional staff like psychiatric nurses to the emergency departments in Battlefords Union Hospital and counsellors in Lloydminster Hospital. So yes.

**Ms. A. Young**: — Thank you. Currently how many psychiatric consultations have emergency departments in the Northwest conducted? I suppose what I'm asking is, are psychiatric consultations offered in the emergency department for patients at risk of suicide 100 per cent of the time? And if not, if you have any measures of what that would be.

**Mr. Miller**: — In response to your question, we do have access to psychiatry consults 100 per cent of the time, 24-7, through an on-call service. So that is in place. And we have a work standard that is described in the auditor's report that directs staff in terms of the steps they need to take for suicide, to perform a suicide assessment, and what follow-up would look like in terms of accessing that consultant service through psychiatry.

**Ms. A. Young**: — Thank you. So I see on page 193 of the auditor's report in figure 1 there are target time frames for out-patient psychiatry services. And then below the auditor notes the actual response times for September 2022.

Are those response targets being met now? And I suppose looking back, were they met in 2023, and what percentage of patients are being assessed within those targets for each category?

**Mr. Miller**: — Response to your question: we have that information. We don't have it available here today, but we can follow up to provide it to the committee.

**Ms. A. Young**: — Thank you. Thank you very much. I appreciate that.

**The Chair**: — Just as we have with all the other undertakings of information, just to confirm that can come through the Clerk to the committee. And is a month's time, four weeks, reasonable to receive that information?

**Mr. Miller**: — Yes.

**The Chair**: — Right on.

**Ms. A. Young**: — Thank you. In her December 2023 report, the Provincial Auditor discussed child and youth wait times in the northeast integrated service area. I'm wondering if you're able to speak to the wait times children and youth experience in the Northwest. At this point in time, how many children and youth clients are waiting for psychology services? And how many adults are waiting as well?

And forgive me. I said psychology services and now I'm second-guessing whether I should be saying psychology or psychiatry, but I hope you understand the intent of my question.

**Mr. Miller**: — Could you actually repeat your question?

**Ms. A. Young**: — Sure.

**Mr. Miller**: — That would be helpful. Thank you.

**Ms. A. Young**: — Sure. So in December 2023 the Provincial Auditor reported on child and youth wait times in the northeast integrated service area, and I'm wondering if you're able to speak to the wait times children and youth experience in the Northwest. And I'm looking for any point-in-time numbers that are available for how many kids, how many children and youth are waiting for services.

[16:00]

**Mr. Miller**: — Thank you for your question. Similar to the last response, we don't have that information at our fingertips today, but we can follow up with a subsequent submission to capture and it would be a point in time of how many are waiting in the Northwest for psychiatry.

**Ms. A. Young**: — Thank you. Thank you very much for that undertaking. I note that the auditor reported that staff vacancies are often the cause for delays in accessing services. Can you speak to whether the Northwest is still experiencing staffing challenges in mental health-related positions? Can you provide data on existing staff vacancies for various mental health-related positions in the Northwest? I'm not an expert. I'm not sure what kind of list would be comprehensive, but you know, psychiatry, registered psychiatric nurses, counsellors, etc.

**Mr. Miller**: — I'm on a roll here. We're going to have to follow up on that one as well. We don't have it at our fingertips, but some of the types of occupations that we would be reporting on are things like social workers, registered psychiatric nurses, addictions counsellors, and so on. And so what we would do is within the four weeks we would pull a report that would show what the vacancies are for those occupations.

**Ms. A. Young**: — Thank you, thank you very much. Maybe a bit of a higher level question about the videoconferencing section of the auditor's report. So I see that the SHA did implement the videoconferencing to provide psychiatric services to communities in the Northwest. What I'm unclear on is would all communities have suitable access on the community side to be able to engage with videoconferencing as a service?

**Mr. Miller**: — In terms of your question about videoconferencing, I can confirm that our SHA facilities in the Northwest have telehealth capability to support videoconferencing with providers.

We also know some First Nations communities also have their own telehealth capability that would connect in to a provider. And then as well, and the auditor's report mentioned the new system that was recently rolled out, Sask Virtual Visit, which is another way, and it can be accessed on your mobile device in order to access a provider out of your home or wherever you might be.

**Ms. A. Young**: — Thank you. Perhaps asking the question the opposite way. Are there any communities in the Northwest that would not . . . Hearing what you've said about mobile devices, so I recognize that depends on people having access to, you know, a cell phone with videoconferencing capabilities, which I recognize you can't track or identify, but is the SHA aware of any communities that wouldn't have access to this service in the Northwest?

**Mr. Miller**: — We're not able to confirm communities that wouldn't have that access, but I will say that the Sask Virtual Visit is a platform that brings that type of access to different communities that might not have a facility.

**Ms. A. Young**: — Thank you. And is there information available within the SHA in terms of where folks are accessing these videoconferencing services from? Do you have information in terms of how many people have accessed this service specifically in the Northwest? As always, if you don't have that today, that's A-okay.

**Mr. Miller**: — So in response to your question about the number of people accessing through telehealth or videoconferencing, that isn't something that we would have easy access to. And so we can take that one away and check with our teams to see how we could go about gathering that information.

**Ms. A. Young**: — Sure. Thank you. And just maybe to expand, my interest in asking this question is obviously this is identified as a response to some of the recommendations and it's been evaluated by the Provincial Auditor. So I'm interested in how many people in the Northwest are accessing this and then of course how the SHA plans on measuring the success of this service as it pertains to obviously increasing the mental health supports for people in the Northwest and reducing suicides.

Maybe taking a step back to a higher level. In the auditor's report it notes the three-year average rate of suicide is 17.9 per 100,000 people from 2018 to 2020. Do you have available the three-year average rate of suicide from 2020 to '23?

[16:15]

**Ms. Smith**: — Just to get clarification, what page were you referring to when you were . . . Or if you have that just to help us see where the source . . .

**Ms. A. Young**: — I didn't write that down. I apologize.

**Ms. Smith**: — Okay.

**Ms. Clemett**: — It's page 192.

**Ms. Smith**: — 192. Thank you.

**Ms. Clemett**: — So the second paragraph, section 2. It's coming from Stats Canada so it's probably that was why it's so dated. But unless you have coroners' data, that would be more current, yeah.

**Ms. Smith**: — Thank you.

**Mr. Miller**: — Just looking at the reference point in the auditor's report, it references Statistics Canada as the source. And we acknowledge that. And we are able to provide a rate for suicide per 100,000 based on the Saskatchewan coroner report.

So not exactly the same data, but in terms of providing a bit of an update, we can say that for the five-year period, 2018 to 2022, the average annual rate of suicides per 100,000 population in Saskatchewan was 15.9. And so that is a decrease from the 17.9, although the time periods . . . there is some slight overlap. And it does go up to 2022.

**Ms. A. Young**: — Thank you. And noting that's the average rate, do you have that year by year?

**Mr. Miller**: — We don't have the breakdown by year accessible now, but we can provide that as a follow-up.

**Ms. A. Young**: — Thank you very much. And one last question in this regard. Is the SHA able to look at that information that comes from the coroner's office, in relation to death by suicide statistics, and identify how many of those people were from the Northwest? Is that a measure that's available to the SHA in order to tell how many people specifically in the Northwest are dying by suicide?

**Ms. Smith**: — Thanks. I think that is one that we would have to follow up with the coroner's office to see what, you know, how they're able to break down the data.

**Ms. A. Young**: — Thank you. Thank you very much.

**The Chair**: — Just following up. Thank you very much on that good question. Thanks for the undertaking to follow up with the coroner on that front. And you'll be able to then supply that information to this committee as well? Is that correct? Sort of in the same way that other information will be?

**Ms. Smith**: — Yes, Mr. Chair. Again we've got some takeaways that we'll have to take a look at and we would work to see what's possible, what's available to be able to get back to the committee as soon as we're able to.

**The Chair**: — Thanks so much.

**Ms. A. Young**: — Thank you. Looking at recommendation 6 specifically, in the status update it indicates that the SHA has expanded the implementation of a process for following up with clients recently discharged to all sites in northwestern Saskatchewan. Can you be more specific in answering what type of care and follow-up is provided to clients recently discharged from emergency departments who are either at a high risk or who attempted suicide?

**Mr. Miller**: — Just in response to your question, when somebody is discharged at high risk of suicide, there is a follow-up process. We have a work standard in place in that our mental health team does an intake to assess the needs and what the care requirements might be going forward. That could be an out-patient type of service with psychiatry or a counsellor or another mental health provider, could be accessing addictions programming — whatever they assess on the intake.

Again, we developed the work standards in order to help drive consistency in this across our different sites to provide that service to patients.

**Ms. A. Young**: — Thank you. And how do you measure success specific to that recommendation and the work that's being done for people leaving medical care who have attempted suicide?

[16:30]

**Mr. Miller**: — Regarding a measure of success for patients getting follow-up following an attempted or being identified as being a high risk for suicide, we would refer back to the Provincial Auditor's report when they did the review of patient files to identify the number that had successfully been followed up on and those that weren't.

And so in this case it's important that, as outlined in our work standard, that the intake process is completed. So the mental health intake worker has been able to contact the patient, and then subsequent to that, that the patient has been able to successfully access the services that they require.

**Ms. A. Young**: — Thank you. And looking at the information available for last year from the coroner's office, many of those who died by suicide in Saskatchewan are Indigenous people. And I'm wondering — I'm not seeing it specifically spoken to in any of the actions indicated here — if you can speak to some of the work being done to address the high rates of suicide amongst Indigenous people specifically in the Northwest.

**Mr. Miller**: — So in response to your question about the rates of suicide amongst Indigenous people — which obviously is very serious, and a lot of our efforts have been focused on promoting suicide prevention in communities that access services or provide services to First Nations communities — I mentioned earlier the Roots of Hope program that is focused on suicide prevention. It's being run out of Buffalo Narrows and it's in collaboration with the community and surrounding area.

There is a tripartite agreement between FSIN [Federation of Sovereign Indigenous Nations], the Ministry of Health, and Indigenous Services Canada that focuses on suicide prevention in Indigenous populations. One of the examples that that group has been running for the last two years is a youth land-based camp which is partly related to suicide prevention.

Also Sturgeon Lake was announced as a new integrated youth services centre recently, and they have focused as well on youth mental health. And then earlier I spoke to a number of positions, mental health workers, that have been added in northern communities that are serving significant Indigenous populations where we've added counsellors and nursing staff and others to support mental health and suicide prevention.

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

**The Chair**: — Any further questions from committee members with respect to this chapter here? I know lots of what we're working through here is heavy stuff as well and some hard realities that folks know throughout this province. So I want to thank those that are involved in the work and thinking of all those that are, you know, working through challenges on these fronts as well.

These aren't new recommendations for us here today. We will have follow-up. Thanks for the many undertakings of information to provide back to this committee as well.

So at this point in time, not seeing any other folks that want to enter in at this time, I'd welcome a motion to conclude consideration of this chapter. Moved by Mr. Nerlien, Deputy Chair. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's carried. Recess for 15 seconds while I consult with our Clerk here, the boss.

[The committee recessed for a period of time.]

**The Chair**: — Okay, folks. We'll continue and we'll move along. And we'll turn our attention to chapter 19, and I'll flip it over to the auditor and her office.

**Mr. Wandy**: — Thank you. The Saskatchewan Health Authority is responsible for the provision of MRI [magnetic resonance imaging] services. Efficient use of MRI services can support timely diagnosis and monitoring of injuries and disease.

[16:45]

Chapter 19 of our 2022 report volume 1 reports the results of our second follow-up of management's actions on the four outstanding recommendations we made in our 2017 audit about the Authority's processes for efficient use of MRIs in Regina.

By February 2022 the Authority implemented one recommendation and continues to make progress on the three remaining recommendations. The Authority implemented the recommendation on page 203 regarding regularly analyzing MRI data to determine causes of significant waits of patients for MRI services.

We found the Authority regularly reviews and analyzes weekly and monthly MRI data to determine causes of significant waits of patients for MRI services, such as staff shortages. The Authority also regularly monitors the timeliness of MRI services that contracted private MRI operators provide.

We found the Authority partially implemented both recommendations on page 204 where we recommended the Saskatchewan Health Authority formally and systematically assess the quality of MRI services that radiologists provide, and that the Authority's board receive periodic reports on the timeliness and quality of MRI services, including actions taken to address identified deficiencies.

In 2019 the Authority began working with eHealth to develop an IT system to help assess the quality of radiologists' interpretations of MRI scans. It plans to use the system to support formal peer reviews of the scans performed. At February 2022 the Authority planned to implement the IT system in 2022-23. Once the Authority develops a process to assess the quality of MRI services provided, senior management expects to determine the nature and timing of reporting required about MRI service quality.

Without formally and systematically assessing the quality of MRI services that radiologists provide, the Authority does not know whether they are providing reliable MRI services. Accurate interpretation of MRI scans can be crucial to proper diagnosis and treatment plans for patients.

We found the Authority partially implemented the final recommendation, on page 205, where we recommended the Saskatchewan Health Authority regularly monitor the quality and timeliness of MRI services that contracted private MRI operators provide.

The Authority had contracts with two private MRI operators, with the private MRI operator in Regina contracted for 5,500 MRI scans per year. The Authority uses detailed reports to help staff analyze its data about timeliness of MRI services provided by contracted private MRI operators. For example, each week staff review the list of MRIs sent to private operators and follow up with the operators if they did not schedule MRI requests in a timely manner to understand the reasons why.

In addition the Authority completes daily checks in the radiology information system to determine whether radiologists, including private operator radiologists, complete timely reports for the ordering physicians. However as I described earlier in my presentation the Authority did not yet monitor the quality of MRI services radiologists provide, including those provided by private operators. It expected to begin doing so in 2022-23. Not monitoring the quality of MRI services provided by the Authority and private operator radiologists can affect whether a patient receives an appropriate diagnosis or treatment plan.

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

**The Chair**: — Thanks so much for what's a really important chapter too and a focus. And just to flag, this goes back, this one here, until I guess 2017, and we've considered this at this table. And anyways we'll turn it over for brief remarks from the deputy minister and then we'll flip it open for questions.

**Ms. Smith**: — Thank you very much. The Provincial Auditor noted that the recommendation to regularly analyze MRI data has been implemented in their 2022 report volume 1. The SHA has implemented a process for regularly analyzing MRI data to determine the causes of significant waits of patients for MRI services and support evidence-based decision making.

MRI wait time analysis is reviewed at every medical imaging provincial executive team quarterly meeting. This team includes operational leaders, radiologists, patient and family advisors, and others who support the diagnostic imaging program in Saskatchewan.

Surrounding the recommendation to assess the quality of MRI services provided, the Health Authority is working with radiologists to develop a peer learning and review program to help assess the quality of radiologists' interpretations of MRI scans. This will be enhanced by technology updates to the provincial information system. The SHA is making significant progress in implementing this program and expects implementation to be complete by June 30th of 2024.

In regards to the recommendation for the board to receive reports on MRI services, the vice-president of provincial clinical and support services receives monthly updates on the current state of MRI wait times. Additionally operational leaders are provided weekly reports to supplement the monthly reporting.

As described previously, the SHA is developing a peer learning and review program to help assess the quality of radiologist interpretations of MRI scans. Reporting from this program will be provided to senior management and the board.

And finally, to implement the recommendation for regular monitoring of the quality and timeliness of MRI operators' services, weekly and monthly reports on timelines are provided to operational and executive leaders who have oversight of medical imaging services. Through ongoing enhancements, the SHA continues to adjust these reports to meet the needs of the team.

Assessment of the quality of the MRI services requires the review of the images and reporting by a separate reviewer. An overall medical imaging services peer learning program, which includes MRI services, is in development. Once the peer review program is fully developed and implemented, appropriate reporting will be developed. Thank you.

**The Chair**: — Thanks for that. I'll open it up now to the committee for questions. Ms. Young.

**Ms. A. Young**: — Thank you. Thank you very much. Sounding like there's significant work under way specifically as it pertains to reporting, which I think I heard is occurring weekly and monthly at different levels to various levels of executives.

Is it possible to provide the committee with updated data on the number of patients currently waiting to be scheduled for a Regina MRI by priority level as seen in figure 1 on page 203, but for, of course, the years 2022 and 2023?

**Mr. Witt**: — Thank you. We can't reproduce that data on that table today for you, but we'll get back. We'll work with our teams and we can see what we can bring back to the committee.

[17:00]

**Ms. A. Young**: — Thank you. Thank you very much for that. Looking at outstanding recommendation no. 3, recommending that the board of the Saskatchewan Health Authority receive periodic reports on the timeliness and quality of MRI services including the actions taken to address identified deficiencies, I'm curious how many people are currently waiting for MRI scans in the province, what the longest wait is, and if you can speak to the causes of any significant wait times.

**Mr. Witt**: — Thank you for the question. There are approximately 11,000 patients waiting for MRIs right now. I don't have the longest waiter in front of me here but what I have is the 90th percentile is waiting around 271 days. But we do see variation within that, so for example, in Regina we're seeing patients in the 90th percentile waiting 351 days.

And in terms of the causes of this, I think there's a number that we consider. In Regina — and really across the province but especially in Regina — we see a lot with HR challenges, hard to recruit MRTs [medical radiation technologist]. They're in high demand across the entire country.

We also see the demand is increasing, and so this is a really good example where we see the value of the reporting that we're doing. And so when you look at the data and you start to break it down by different geographic areas, you can really see the demand and the capacity within those areas. And when you break it down, you could see in Saskatoon we actually hit some of our 90th percentile targets, again because the demand was aligning with the capacity within that city.

In Regina we don't have that same alignment. And so we were able to take that data and then work with the Ministry of Health, and we're going to be adding an in-hospital MRI system to Regina. It's going to start as a portable MRI until we can get the permanent one in place. And so it's just a really great example of how we can align the data that tells the story in terms of what are those key investments that we need to make that will be really the most impactful for the total province.

**Ms. A. Young**: — Thank you very much. I have two follow-up questions to that. I was going to ask, you know, you mentioned the staffing challenges which we've spoken about earlier today, and so I was wondering if you are able to identify kind of geographically what facilities were experiencing staffing challenges, where those were in the province.

And I was also curious. You mentioned the portable scanner in terms of an investment. How many MRI scanners does SHA currently operate, and which facilities are those in?

**Mr. Witt**: — Thank you for the question. I would say in terms of staffing we would have staffing challenges across every MRI sort of facility that we have — so Saskatoon, Regina, Moose Jaw. Different collective agreements allow us to work with our staffing.

But we also, you know . . . You recruit. We add some new graduates, and then maybe we have some staff who may go on maternity leave. So it's a very fluctuating kind of thing that we're constantly monitoring and having to adjust and recruit.

In terms of the number of MRIs, so in Saskatoon at RUH [Royal University Hospital] we have two MRIs, and we have one at City Hospital and one at St. Paul's. In Regina at RGH [Regina General Hospital] we have two MRIs, and then we have the future, planned MRI that's going to go into Pasqua Hospital. It will start off at RGH, the portable one, while we do the construction at Pasqua Hospital. RGH has the existing pad and infrastructure, so it's just that's the quickest way to get it in. We will move that temporary infrastructure to Pasqua Hospital because we want to get that patient flow working and support the Cancer Agency as

well too. So then we'll have the permanent magnet there.

In terms of community MRIs as well too, we have two in Saskatoon and two in Regina as well too. And sorry, don't want to forget Moose Jaw. Wigmore Hospital has an MRI system as well too.

**Ms. A. Young**: — And forgive me, your community MRI is the privately operated MRI?

**Mr. Witt**: — Yes.

**Ms. A. Young**: — Okay. Great. Thank you. So looking at the two outstanding recommendations and the reporting that is under way, the SHA is tracking the number of patients accessing MRIs, both through public and through private delivery.

I suppose I'm looking at whether the wait times are comparable for private operators as they are for the public system, as well as the concerns that have been identified around quality; if people accessing these services in Saskatchewan can expect a similar wait time, but also a similar quality through both public delivery and private delivery. And then if that information is tracked, which it appears to be, if you have that for the last few years for both the public and the private operators.

**Mr. Witt**: — In terms of the wait times, there's actually no separate wait time for public versus private. How we do it is we basically incorporate it into our current wait times, so we treat a community magnet for those patients just as we would our own magnets. And so the patients, they flow seamlessly through our system. So you know, if you're deemed to require this certain type of imaging and we earmark you for a community magnet versus an in-hospital one, you just flow there and all that tracking is all within the same scope.

In terms of the quality, I think there's two elements. One is in terms of quality of radiologists. All private MRI radiologists are accredited by the College of Physicians and Surgeons within Saskatchewan.

But I think more importantly is what the auditor is working with us on is the new peer learning and peer review process that we want to implement. We're very excited about this, and we're very close to actually turning that on and implementing it.

And the value of this is it's really going to allow us to, through a learning and through a peer review process, assess the quality of the reads from, not just in Regina and not just the private radiologists, but all radiologists across Saskatchewan that are reading for the SHA. And it's done in a way that is going to be able to learn and grow and help the radiologist, if maybe we find that some reports are lacking, and be able to actually be an opportunity to mentor and learn and actually support and identify where maybe there are some challenges with the reads, but also where we can actually take really good readings and then help teach other radiologists to grow and be better.

[17:15]

**Ms. A. Young**: — Thank you for that clarification. I think it helps me understand a little bit more. So then the rationale for the two different recommendations, no. 3 and no. 4, one is speaking to, at least by my read, kind of traditionally delivered MRI services, and the fourth recommendation is speaking to private delivery. The reason those are then broken out, hearing what was just said, like wait times are the same. You just get funnelled to where you get funnelled. The concern is really about ensuring that there's the same quality being delivered at . . .

**Ms. Clemett**: — Absolutely, yeah. And like, as the SHA has indicated, that really from that quality oversight perspective, it'll be across all radiologists, whether at the private or at . . .

The other thing is there was a component to timeliness here, and now we are satisfied that the timeliness . . . And there is, you know, monitoring that should be taking place from that oversight perspective, again from the SHA side, when it comes to are the private operators doing timely scans. And we found they are, and now we just want to see that quality of rollout being rolled out to all radiologists, whether you're working at a private operator or for the SHA.

**Ms. A. Young**: — Okay, thank you. I appreciate the clarification. It helps me. My last question on this, is there — I don't know what the right words are — is there a cost differential for a patient accessing a private or a traditionally delivered MRI?

**Mr. Witt**: — Your question, I believe it said something like cost to the patient, but I don't think that was what you were looking for.

**Ms. A. Young**: — No, not to the patient. Yeah.

**Mr. Witt**: — Yeah. I made an assumption there.

**Ms. A. Young**: — I assume we're not charging patients.

**Mr. Witt**: — No, no.

**Ms. A. Young**: — Yeah. Unless something's changed.

**Mr. Witt**: — That would be the easy answer. So in terms of the cost differential, to contract out there is a process that we do in terms comparing the values of in-hospital services versus a contracted out service. We went through this years ago when we went and did the initial contracts with the service providers. It was found that the private provider service was more cost effective than the hospital-delivered service there. And that still remains.

**Ms. A. Young**: — That remains true. And would those figures be — didn't go back and look till 2016 or whenever that was — those figures would remain the same then.

**Mr. Witt**: — Yeah. There's inflationary changes year over year, but inflationary changes impact both systems as well too.

**Ms. A. Young**: — Thank you. And saving me the research, do you have the current numbers with inflationary changes for the past however many years?

**Mr. Witt**: — I wouldn't have them here today. No. Well, let me just look here.

Thank you for the question. The SHA, it's a SHA-negotiated rate

with a third party. We're unable to disclose that rate right now just because it might impact future negotiations with them. And so yeah, for now it's kind of a confidential rate.

**Ms. A. Young**: — Fair enough.

**The Chair**: — Do you have other questions?

**Ms. A. Young**: — No, I'm good. Thank you, Mr. Chair.

**The Chair**: — Okay, I think there's a bunch more questions coming over here. Any further questions, folks? Not seeing any with respect to this important chapter. Thanks as well for information you're going to be providing back and the work that you've committed to to ensure implementation on these fronts. That's all really appreciated.

I would welcome a motion to conclude consideration of this chapter. Moved by Ms. Lambert. All agreed?

**Some Hon. Members**: — Agreed.

**The Chair**: — That's carried. Respecting the time of the day which is 5:26 p.m., we won't be proceeding with the rest of the items on the agenda today. We will deal with those at a future hearing as a committee.

At this time I just want to say thank you so much to Deputy Minister Smith and the awesome team of officials that have joined us here today. And we know there's a whole bunch of others that are patched in to this work and connected to the considerations here today and involved in implementation and providing care across Saskatchewan.

We know our health system is complex, with many pressures and challenges and lots of care within it. We know lots of the stuff we're discussing is complex as well, with often not simple answers, so thanks to you all that work to provide care and health care and services to the people of the province from corner to corner to corner.

Deputy Minister Smith, two good full days here with you. Any final remarks on behalf of your team before we shut this thing down?

**Ms. Smith**: — I just want to say thank you to the committee for the time and the questions that were brought forward because I do think it enables us, along with our partners within eHealth specifically and the SHA, to be able to show a lot of the great work and progress that is happening across the system. And so having some time to do that today and yesterday, we really appreciate the questions.

And again to the team behind me and back at various locations and to the system as a whole, it's really the individuals that work within the health care system that are working to implement all these changes. And I think we all really appreciate the efforts that go on every single day in our province, so thank you.

**The Chair**: — No, that's great. Thank you to the auditor and their team for their dedication, their focus on these fronts, and their diligence in following up as well, and the relationship where the entity, the ministry, the Health Authority, where they work together with the auditor on these fronts. To our Clerk and Hansard and all the committee members, thanks for a good couple days.

So with all that being said, I know the member from Melfort is hungry. I would welcome a motion of adjournment. Moved by Mr. Harrison. All agreed?

**Some Hon. Members**: — Agreed.

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

[The committee adjourned at 17:28.]