Yukon Legislative Assembly

Issue 8 35th Legislature

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Public Proceedings: Evidence

Tuesday, December 12, 2023 — 1:00 p.m.

Chair: Currie Dixon

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Chair: Currie Dixon
Vice-Chair: Kate White

Members: Hon. Jeanie McLean
Hon. Richard Mostyn
Scott Kent

Clerk: Allison Lloyd, Clerk of Committees

Witnesses:

Office of the Auditor General of Canada

Andrew Hayes, Deputy Auditor General
Tammy Meagher, Director

Executive Council Office

Justin Ferbey, Deputy Minister and Cabinet Secretary
Brian MacDonald, Assistant Deputy Minister for Aboriginal Relations

Department of Health and Social Services

Tiffany Boyd, Deputy Minister
Sheila Thompson, Interprofessional Practice and Chief Nursing Officer
Jared Wong, Senior Advisor

Department of Community Services

Matt King, Deputy Minister
Greg Blackjack, Civil Emergency Planning Officer

EVIDENCE
Whitehorse, Yukon
Tuesday, December 12, 2023 — 1:00 p.m.

Chair (Mr. Dixon): All right, we will get started now. I will now call to order this hearing of the Standing Committee on Public Accounts of the Yukon Legislative Assembly. The Public Accounts Committee is established by Standing Order 45(3) of the Standing Orders of the Yukon Legislative Assembly. This Standing Order says: "At the commencement of the first Session of each Legislature a Standing Committee on Public Accounts shall be appointed and the Public Accounts and all Reports of the Auditor General shall stand referred automatically and permanently to the said Committee as they become available."

On May 17, 2021, the Yukon Legislative Assembly adopted Motion No. 11, which established the current Public Accounts Committee. In addition to appointing members to the Committee, the motion stipulated that the Committee shall have the power to call for persons, papers, and records and to sit during intersessional periods.

Today, pursuant to Standing Order 45(3) and Motion No. 11, the Committee will investigate the Auditor General of Canada's performance audit report on COVID-19 vaccines in Yukon.

I would like to thank the witnesses from the departments for appearing. I believe that the Deputy Minister of the Executive Council Office, Justin Ferbey, will introduce these witnesses during his opening remarks. I would also like to welcome the officials from the Auditor General of Canada who are present today. They are: Andrew Hayes, Deputy Auditor General, and Tammy Meagher, director.

I will now introduce the members of the Public Accounts Committee. I am Currie Dixon, the Chair of the Committee and the Member of the Legislative Assembly for Copperbelt North; to my left is Kate White, who is the Committee's Vice-Chair and the Member for Takhini-Kopper King; to her left is the Hon. Jeanie McLean, Member for Mountainview; to her left is Scott Kent, Member for Copperbelt South; and finally, behind me is the Hon. Richard Mostyn, Member for Whitehorse West.

The Public Accounts Committee is an all-party committee with a mandate to ensure economy, efficiency, and effectiveness in public spending — in other words, accountability for the use of public funds. The purpose of this public hearing is to address issues of the implementation of policies, whether services were effectively and efficiently delivered, and not to question the policies of the Government of Yukon. In other words, our task is not to challenge government policy but to examine its implementation. The results of our deliberations will be reported back to the Legislative Assembly.

To begin the proceedings, Andrew Hayes will make an opening statement on behalf of the Office of the Auditor General of Canada. Justin Ferbey will then deliver remarks on behalf of the departments. Following the opening statements, Committee members will ask questions. As is the Committee's practice, the members devise and compile the questions collectively; we then divide them up among the members. The questions each member will ask are not their personal questions on a particular subject but those of the entire Committee. After the hearing, the Committee will prepare a report of its proceedings, including any recommendations that the Committee wishes to make. This report will be tabled in the Legislative Assembly.

Before we start the hearing, I would ask that the questions and answers be kept as brief and to the point as possible so that we may deal with as many issues as possible in the time allotted for this hearing. I would also ask that Committee members and witnesses wait until they are recognized by the Chair before speaking. This will keep the discussion more orderly and will allow those listening on the radio or over the Internet to know who is speaking.

We will now proceed with Andrew Hayes' opening statement.

Mr. Hayes: Mr. Chair, we are pleased to be in Whitehorse today to discuss our audit report on COVID-19 vaccines in Yukon, which was presented to the Yukon Legislative Assembly on June 20. I am accompanied by Tammy Meagher, the director who was responsible for the audit. I would like to respectfully acknowledge all Yukon First Nations and acknowledge that this meeting is taking place on the traditional territories of the Kwanlin Dün First Nation and the Ta'an Kwäch'än Council.

As the COVID-19 pandemic evolved across the world, the federal government procured vaccines and coordinated their distribution to the provinces and territories. Our audit examined whether Yukon's Department of Health and Social Services, Department of Community Services, and Executive Council Office managed the rollout of COVID-19 vaccines to protect the health and well-being of Yukoners.

Overall, we found that the three departments worked well together to vaccinate residents quickly and on a priority basis, despite a lack of up-to-date and complete pandemic plans. Within weeks of receiving the first shipment of doses, the departments vaccinated vulnerable groups in Whitehorse and set up a mass vaccination clinic in the capital to progressively reach all age groups.

In parallel, mobile health teams travelled to remote communities so that anyone 18 years and older could be vaccinated in or near their home community. By November 2022, 81 percent of Yukoners had received two doses of the vaccine.

While the territorial government's approach to the rollout was effective at getting people vaccinated, we found weaknesses in the monitoring and reporting on the vaccine rollout. The Department of Health and Social Services did not have an efficient inventory management system to track the supply and inventory of vaccines and relied instead on manual documentation. This led to errors and discrepancies — for example, in the inventory levels and waste reported to the Public Health Agency of Canada. This also prevented the department from knowing exactly how many vaccines it had in its inventory at any given point in time.

We also found that the three departments did not give First Nations the opportunity to meaningfully participate in the planning of the rollout. For example, despite regular meetings with the departments, First Nations were briefed late on the rollout plan and had limited input throughout its implementation.

The Government of Yukon has recognized that there is a historical legacy of colonialism and discrimination in Canada and that many Indigenous people have experienced trauma, including discriminatory health care policies and practices. In this audit, we saw a missed opportunity to better understand and meet the needs of First Nations through meaningful collaboration.

Engaging with First Nations should not merely be a box to be ticked on a list of required actions. It is a commitment that must be acted on to address and break down barriers, improve sensitivity and inclusion, and rebuild trust. The Government of Yukon needs to put actions behind its words and work in partnership early, often, and meaningfully with First Nations — not just in emergencies but across the spectrum of programs and services it provides. This means engaging with First Nations at the outset and meeting with them regularly to reflect their feedback in government decisions and processes.

Mr. Chair, this concludes my opening statement. We are happy to answer any questions that the Committee may have. Thank you.

Mr. Ferbey: Good afternoon. My name is Justin Ferbey, and I am the Deputy Minister for the Executive Council Office and the Cabinet secretary. Thank you for the invitation to appear before the Standing Committee on Public Accounts and answer questions related to the Office of the Auditor General's report on Yukon's COVID vaccine rollout.

I am pleased to be joined by Mr. Brian MacDonald, the Assistant Deputy Minister for Aboriginal Relations in the Executive Council Office; Department of Health and Social Services officials Ms. Tiffany Boyd, the deputy minister, Sheila Thompson, interprofessional practice and chief nursing officer, and Jared Wong, senior advisor; from the Department of Community Services, Mr. Matt King, deputy minister, and Mr. Greg Blackjack, the civil emergency planning officer.

There are always lessons to be learned after the emergency or critical event, which is why our response planning includes after-action reviews. These reviews scrutinize our efforts, ask difficult questions, and highlight where we fell short. They are conducted with the goal of ensuring that we continue to improve.

We reviewed the report from the Auditor General with the same lens. We recognize the importance and value of all of the Office of the Auditor General's recommendations. We appreciate their work and know that it will assist us with future pandemic responses and other types of emergencies.

The pandemic hit us unexpectedly. We all watched as the health care system and those working within it were pushed to their limits. Managing these pressures requires constant adaptation, creative solutions, and making decisions in real time. The Yukon had never attempted a vaccine rollout like this one executed in the early days of 2021, and we were the first jurisdiction in Canada to attempt rolling out the vaccine to the entire population within 90 days.

It required government employees across several departments to go above and beyond the responsibilities in their jobs to ensure a safe, effective vaccine rollout. From greeters at vaccine clinics to cleaning personnel, security staff, flow navigators, immunizers, and community liaisons, the team was organized, positive, and motivated.

People worked incredibly long hours, drove between communities in the depths of winter, and spent many days away from families and friends. People demonstrated true leadership and the values of community service, which leads many of us to work with government in the first place.

I am proud to be part of a team that supported these efforts. It was a historic event and one that ensured positive health outcomes to protect Yukoners. While there are lessons to be learned and we need to learn from this effort, we understand the importance of ensuring Yukon government plans are revised regularly and how critical it is to keep people trained in incident command principles and that we are prepared to manage future emergencies.

I look forward to this opportunity to discuss the lessons learned and share how we have implemented positive changes so that we are even more prepared to support Yukoners through potential future challenges.

Thank you. I look forward to answering your questions.

Chair: Thank you very much, Mr. Ferbey. I appreciate both of those opening comments — from the OAG as well as the Yukon government. We will now proceed with questions from the Committee.

Ms. White: The first questions are for the officials from the Office of the Auditor General of Canada. Can you please explain how the Office of the Auditor General of Canada selected COVID-19 vaccines in Yukon as a matter for evaluation?

Chair: Just one brief reminder: If you are going to be responding, if you could just give me some sort of a physical indication so that I can know whom to announce.

Mr. Hayes: Thank you very much. With all of our audits, we undertake a risk-based analysis of what to select and when. When we were looking at the next audit to do in Yukon at the time, we selected this work, because the COVID-19 pandemic had been one of the most serious public health emergencies that the country and indeed the territory had faced in many years. This audit is important, because vaccines are one of the most important public health tools for preventing serious illness and controlling infectious disease outbreaks, such as COVID-19. Our audit was intended to identify how the government acted and implemented the rollout.

We ultimately found that there were some very good practices and some areas for improvement, which we hope can lead to an improved approach in the future, if that is needed, and that is what our recommendations are geared toward.

Ms. White: How many similar audits have been done by the Auditor General's office in Canada?

Mr. Hayes: Our office undertook a number of COVID-19 audits — some related to vaccines — but before I

get into those, in the federal context, we did audits on pandemic preparedness. We did two audits on procuring personal protective equipment and medical devices, and we have done numerous audits on COVID-19 benefits. In the federal context, we also did an audit of procuring COVID vaccines. The way that we looked at it, the federal government procured those vaccines, rolled them out to the provinces and territories, and many provincial auditors general had a look at how that was looking in their provinces. We looked at the rollout in both Yukon and Nunavut.

What we found — in the federal context, which is important — is that they responded quickly to the urgency of the pandemic in 2020 and secured enough doses for any Canadian who chose to be vaccinated to get that vaccine. In the federal context, we identified that there were problems with wastage. The efforts by the federal government to minimize that weren't successful — in part because of delays in implementing information technology systems and in part because there were information-sharing problems with provinces and territories. That links to what we were looking at here. What we were looking at, obviously, was where the territory picks it up from the federal government, rolls out the vaccines, and how the information-sharing works back to the federal government.

As I mentioned, the provincial auditors general — I can't tell you exactly how many did vaccine audits, but I think that there were quite a few.

Ms. White: How does the Yukon compare to other jurisdictions?

Mr. Hayes: The purpose of our audit wasn't really to do a direct comparison with other jurisdictions, but I can provide a bit of information.

In most of the audits that we have seen, each jurisdiction has had its unique challenges, and there have been some consistent findings — for example, the need to have complete and up-to-date plans for emergencies, including for pandemics; the need to have information-sharing agreements in place — it's not okay to wait until there is an emergency for those to be put in place — and the importance of systems to track inventory for vaccines and wastage.

In terms of the Yukon, I will say that the information-sharing with the federal government was pretty good, comparatively.

The other thing that I would say in terms of wastage is that the numbers for the Yukon were similar to some other jurisdictions. For example, in our report, we identified, in the period that we are looking at, that there was about an 11-percent wastage amount. That is very similar to Ontario; they were at nine percent. Manitoba did a little bit better; they were at five percent. Nunavut had a higher amount of wastage; they were at about 16 percent, but 15 percent of their vaccines weren't able to be accounted for. Overall, wastage is expected. The Yukon government did reasonably well in terms of managing it.

Ms. White: So, the following general questions are directed to the departments.

Looking back at the COVID-19 vaccine rollout, are there changes outside of this audit report that you have considered and would change for the future?

Ms. Boyd: Good afternoon, everyone.

When we look back at the COVID-19 vaccine rollout, it was a challenging and unique time. We were working under extreme pressure with constantly evolving information, while simultaneously trying to keep partners, First Nations, and Yukoners informed. Our employees were incredible. They stepped up and they delivered. Due to their extraordinary efforts, we led the country in getting all of our eligible residents vaccinated in record time.

The Department of Health and Social Services was responsible for the clinical service delivery of the vaccine, but many other Government of Yukon departments and other partners were key players in enabling this delivery so that every Yukoner could have access to the vaccine if they chose. I know that this experience was deeply personal to every Yukoner, and we all have our own experience and our own story to tell.

I would like to take a moment and recognize the involvement of everyone involved in supporting the Yukon's COVID-19 response and vaccine rollout. This is a challenging period with lessons learned, but the day-to-day efforts from front-line delivery to the logistics and planning made such a difference in the lives of Yukoners, our ability to keep people safe, and to begin relaxing public health measures once it was safe to do so.

Logistical planning for distributing the vaccine was a massive undertaking, especially with the impacts of winter weather and short daylight hours for flying in and out of some communities.

Not all communities had enough accommodations for teams to stay overnight, and this complicated planning. Other complications were uncertainty of shipment dates, and the quantities contained in those shipments were often less than expected in the initial vaccine rollout planning.

Yukon was well-positioned to respond. Based on our previous pandemic planning, we had stockpiles of personal protective equipment and vaccine delivery supplies already staged across the territory and routinely inventoried following the H1N1 planning from 2009. Yukon developed multiple scenario plans for the various vaccines being developed and their specific requirements, as we were unsure what vaccine we would receive and in what quantities. We were pleased that Canada and other provinces recognized the unique needs and circumstances of the north, particularly in terms of delivering health care. The three territories developed an approach for a pan-territorial allocation for all territories to have access to the vaccine in the first quarter of 2021. By mid-December, we were preparing for a February 1 vaccine rollout. However, this rapidly changed, as vaccines were approved through the regulatory process ahead of the initial estimates. As you know, we administered our first COVID-19 vaccine in the territory on January 4.

The goals of our vaccine delivery process were to: first, protect those most vulnerable; second, protect health care capacity; minimize spread; and lastly, protect critical

infrastructure. While hindsight has provided us with new insights into the vaccine rollout, we are incredibly proud of the tremendous efforts to quickly, efficiently, and safely create access to the vaccine, while adjusting our approach around unique challenges. This was a complicated and complex undertaking, and I would like to briefly acknowledge some of the factors our teams and partners were faced with to paint this story.

It is important to recognize that, during our initial planning stages, there were two different vaccine candidates, including one from Pfizer and one from Moderna. Each had different criteria for storage and transportation. These were the first mRNA vaccines, and undertaking and understanding the complex logistical and administration criteria presented new challenges for staff. One of the two leading vaccines required that it be held at an ultra-low temperature during long-term storage and transportation, so that meant from between minus 60 to minus 90 degrees Celsius, requiring specialized freezers. This would have been logistically challenging for northern jurisdictions with long transport times to reach communities.

In preparation with the federal government, the Yukon did receive ultra-low temperature freezers to support this vaccine's needs should the Yukon be allotted that vaccine. All freezers and fridges had to be alarmed for temperature fluctuations and alarms monitored 24/7 in Whitehorse. Vaccines were initially shipped with dry ice, which is logistically challenging for air transport. Dry ice can only be used in well-ventilated rooms and handled with extreme caution. All fridges and freezers had to be connected to plugs with emergency backup power. All shipments had temperature trackers that needed to be uploaded to a computer monitoring system to ensure that the vaccine remained at the appropriate temperature during transport. This assessment was done prior to starting each clinic.

Neither vaccine can be agitated or shaken, which impacted transportation, storage, and handling. During the initial rollout, vaccine containers had to be transported belted into a seat, whether that was on a plane or in a car. At times — in fact, many times — nurses, who were aware of the limited and precious supply of vaccine allocated to Yukon, were protecting the supply of vaccine by physically holding them on their laps during transport.

The vaccine could also not be refrozen after being thawed, which impacted our ability to plan to ensure that we were maximizing a limited supply of doses. Given that there were two different vaccine products with different handling, we needed to remain responsive to different scenarios.

Pfizer needed to be stored at ultra-low temperatures of minus 60 to minus 90 until expiry or for up to two weeks at 15 degrees Celsius to minus 25 degrees Celsius. After removal from refrigeration and punctured, the product needed to be used within six hours or discarded.

Moderna needed to be frozen at minus 20 and protected from light. That product had to thaw at room temperature for one hour or 2.5 hours in a fridge before it could be drawn up for use. This required planning on the number of doses that would be drawn and planning to reduce wastage, while minimizing handling. After being punctured, the product had to be used within six hours.

Initial dosing interval recommendations were 25 to 35 days apart. This planning was initially centred on the schedule with an ideal interval of 28 days. As updates were received, the planning was adapted to different dosing intervals and tracking and then scheduling or rescheduling second doses in both Whitehorse and the communities within those expected time frames. This was done by a small planning team and was a continuous challenge.

As we became aware of new shipment dates and monitored vaccine usage, we would recalculate how many appointments we could add and when we could accommodate walk-ins. As dates changed for approvals, the securement of logistics for mobile teams became more urgent. This included: procuring and to receive all clinical and logistical supplies; procuring land and air transport options; procuring space for mobile clinics in each community, including a backup location; procuring hotels and lodging for mobile staff; procuring food and other necessities for mobile staff; procuring and adding new security measures for vaccine storage and security; planning travel sequencing for both mobile teams, including backup plans, which included calculating hours of daylight and official darkness, as this impacted the time on the ground or meant driving to the next community after long days in clinic.

We had to recruit and hire or reassign staff within the public service and develop and procure an online booking system. This had to be built with our required appointment logistics and data uploads once we confirmed a start date. This work happened over the holiday season: develop three training modules specific to the rollout of the Moderna vaccine; develop and launch communications products; develop and finalize product for proof of vaccination and train staff — staff also completed First Nations 101 and San'yas training — design the layout for mobile clinics based on procured space and COVID protocols, which was unique to each community; liaise with First Nation governments and communities to coordinate vaccine rollout and build awareness of the vaccine; negotiate with the federal government and British Columbia to provide vaccine product to Atlin so that they could vaccinate their population, as well as create access in Watson Lake for Lower Post. We had to schedule all the teams. This was no small undertaking, and the way staff mobilized to respond to these challenges was absolutely remarkable.

As part of this process, we also needed to plan for access to the vaccine to respond to geographic and population factors. Community groupings were determined by both geography and population numbers, with two mobile teams travelling simultaneously, in addition to the operation of the mass clinic. The initial plan was for all Yukoners who wished to receive the vaccine to have access to the first dose within six weeks. This adapted as our allocations were known. To the extent possible, we also worked to adapt our rollout around community need. For example, one rural community was not quite ready for the vaccine and requested that they be moved to a later time and sequencing of visits, and this was certainly accommodated.

Sequencing for the initial rollout was determined by a variety of risk considerations, including the community's health care capacity, location — for example, if it was a border community or fly-in only — demographic factors influencing susceptibility to the virus, the National Advisory Committee on Immunization and the special advisory committee's recommendations priority recipients.

Finally, we also mobilized around ensuring vaccine clinic locations could meet a variety of pressures and needs, such as size of the population served, required spacing between stations, wait areas for before and after appointments, and ensuring accessibility, safety, and appropriate clinic flow-throughs.

Clinic throughput at the mass clinic in Whitehorse was one client every six minutes, which is approximately 10 clients per hour per immunizer. This meant that we could immunize a thousand people per day in Whitehorse when we had all immunizers in place. In communities, throughput was approximately one client every 10 minutes per immunizer to allow additional time for questions or supports if wished.

We also sought to support those living in communities who did not access a vaccine during a community visit to travel to the nearest community or be accommodated in Whitehorse, if easier, in order to access their vaccine. Teams held huddles in the early days and shared their "whys" for wanting to be involved in this historic implementation. Some were very personal and related to helping their communities or doing it for family members or friends they had lost in this or previous pandemics or who were significantly ill with COVID in other parts of the country.

The dedication and commitment were palpable. I apologize for the length and detail in these remarks. I hope it will provide a better picture and understanding as we discuss the incredible effort as well as our lessons learned in areas for improvement.

Although there is always room for improvement, I am very, very proud of the hard work our team did to meet these goals. Following evidence to develop a COVID-19 vaccine strategy and become one of the first jurisdictions in Canada and the world to vaccinate its population, I feel the Yukon is better positioned than ever to manage future health emergencies. Of course, there is certainly always room for improvement, and I appreciate the work and findings of the OAG, and I want to also recognize Yukon University and the Council of Yukon First Nations, who have also looked into this and provided some valuable insight to us.

Outside of those two reports, two additional areas for improvement would be internal records management and employee recognition. Regarding records management, during the OAG review, we realized that we could have done a better job by creating a standardized electronic filing system for all project-specific documents at the beginning of the process. Significant work across the department and government and weekly calls with First Nation governments occurred throughout our response, and a centralized filing system would have enabled us to more readily recall and receive that information. Creating a more centralized filing system is certainly a lesson learned. That said, it is important to note that this had no impact on safety or the delivery of the vaccine.

With respect to employee and health care provider recognition, reflecting back, we could have done a better job recognizing and rewarding the incredible work that everyone involved in the vaccination campaign contributed. In hindsight, we also recognize that, while we were moving quickly, we could have placed more emphasis on team building. No one anticipated how long the pandemic and work associated with managing the crisis would last. In the future, plans need to include rotations of staff to ensure that people can get time off and the relief they need to help people stay healthy and well.

It's critical now to emphasize that employees worked exceptionally hard, putting in long hours and sacrificing time with their loved ones over the Christmas holiday season during the pandemic. We need to plan for ways to recognize our employees' dedication to this work and the significant contribution they have made in a meaningful way. We would also like to take this opportunity to thank them and extend our gratitude and recognition again today.

Our vaccination campaign was a great accomplishment and a great success. It was only successful because of the hard work of individual Yukoners, and we owe them a great deal of gratitude.

Chair: Thank you, Ms. Boyd. This is my opportunity to remind both witnesses and Committee members to keep their answers and questions as brief as possible.

Ms. White: We are looking at increased flu, RSV, and an uptick in the latest version of COVID. Can the departments provide an update on the implementation of the Auditor General's recommendations so far? Can you provide a timeline for completion?

Chair: I'm looking for a physical indication from someone to respond.

Ms. Boyd: Considerable work is underway to reflect upon lessons learned during the pandemic and opportunities for improvement. For example, in the department's 2023-24 main estimates, we budgeted $3.545 million to rebuild a number of long-term resiliency measures to remain responsive to COVID-19 and other public health needs. This includes additional staff and infection control measures in our long-term care homes, including Dawson City. We have added three more permanent staff in our community health vaccination and immunization program, and we have dedicated additional resources to emergency management.

The Yukon's health care system is better prepared than ever to address increased flu, RSV, and the latest version of COVID. Immunizers continue to deliver an unprecedented number of vaccines across the Yukon to meet the public health needs of Yukoners. We have also expanded the scope of practice for pharmacists so that they are better integrated into our health system, and this increases the number of providers able to provide vaccines to Yukoners.

In September, we established a permanent vaccine clinic at NVD Place mall at the corner of 4th and Ogilvie. This is another example of our efforts to integrate COVID-19 supports into the ongoing health service operations. The clinic offers mass

vaccination programming for both flu and COVID-19, which are currently available to all Yukoners. The clinic also offers appointments for publicly funded vaccines for people aged five and older.

With respect to the OAG recommendations, we have accepted all seven and are making progress on each of them. Timelines for completion of responses to each of the recommendations are in various stages of operationalization. Most will be completed within the coming 12 to 24 months. Others, particularly those that require regulatory legislative review and action, will take longer.

We are pleased to advise that one of the seven recommendations — a new vaccine inventory management system — is now fully functional and that work is considered complete. Work on the review of the *Civil Emergency Measures Act* and the *Public Health and Safety Act* is proceeding as scheduled, and it is anticipated that engagement with the Yukon First Nations and municipal governments will start this spring.

The Department of Health and Social Services is currently progressing work on overarching cultural safety and has vetted cultural competencies into management's PEPs and will continue to move forward with this important and necessary work through the entire department.

Ms. White: What is the timeline for the legislative reviews that are being conducted?

Mr. King: For the review of the *Civil Emergency Measures Act* and the *Public Health and Safety Act*, the research and the paper review are underway. That will include a number of things, including looking at other jurisdictions and the base policy work that is required. In the spring of 2024, Community Services and Health and Social Services plan to engage Yukon First Nations directly and municipal governments directly to better understand the gaps and the policy issues from First Nation government and municipal government perspectives.

The policy issues that are identified through that engagement process will lead to future decisions around more broad engagement, but certainly, the work is underway on the review of the *Civil Emergency Measures Act* and the *Public Health and Safety Act*. Timelines will likely — by the time the engagement process is concluded and future decisions are made, we are likely looking at sometime after 2025-26.

Ms. White: What do the witnesses believe are the key factors in the effective rollout of the vaccines throughout Yukon?

Ms. Boyd: There are many important factors that led to Yukon's successful COVID-19 vaccination campaign. First and foremost — I can't emphasize enough and I will probably say it many times today — is the dedication of health care staff to the health and well-being of Yukoners. People rose to the challenge, and they took the privilege that we had of receiving the vaccine prior to other parts of the country and the world very seriously. Having professional and competent staff here in the Yukon, including staff with expertise in public health, was essential to our success.

The collaboration between community health programs, community nursing, long-term care, the chief medical officer of health, the Yukon Hospital Corporation, and so many others was essential. The collaboration with other government departments was also critical. The government declaring a state of emergency gave us flexibility within the government to quickly deploy people from one department to another, and this was critical to being efficient and effective.

Community Services and the Executive Council Office's Aboriginal Relations division played a vital logistical role with our mobile teams, Balto and Togo, who visited every community multiple times and sometimes to great fanfare — for example, in Haines Junction, where community members greeted the mobile teams with a reported 140 ice lanterns along the highway, which is the picture on the front of the report. As you know, the OAG confirmed that no Yukoners were denied access to the vaccine, which was critical, due to lack of resources.

The vaccine rollout was complex, impacted by a limited supply and challenging logistical considerations, which I have outlined, and a need to ensure that we provided access to as many people as quickly as possible. I want to commend the ways that staff handled many of these challenges. For example, we know that, in order to minimize dose wastage, immunizers worked to identify individuals at the end of the day who had not received their vaccine or may not have been eligible in order to offer them their vaccine and reduce vaccine wastage.

As you know, the OAG confirmed that no Yukoner was denied access to the vaccine due to lack of resources. Community Services and the Executive Council Office COVID-19 liaisons worked diligently to provide Yukon First Nations, transboundary Indigenous governments, and municipal and community government officials with important information about the vaccine rollout, as it was available, to ensure that questions, concerns, and feedback were directed to relevant Yukon government department leads.

Community involvement was also incredibly essential. We had many meetings, telephone calls, and community visits prior to the mobile teams arriving in each of the communities. There were weekly calls with First Nation governments. Community Services and Aboriginal Relations sent in teams ahead with support people with information on the vaccine and to support appointment-making. They also set up information kiosks in accessible places and worked with community leadership on clinic preparation. Community health care staff were also available to support the public with booking appointments. Where possible, when requested, the planning teams worked with their community leaders to change scheduled dates to accommodate the needs and readiness.

The arrival of the mobile clinic teams in communities was preceded by an advance team made up of three to five members whose jobs were to engage community members, share information about the Yukon's vaccine plan, and help get people to the clinic when the teams arrived. The vaccine rollout was broadly supported at all levels within the territory. Many community leaders, elected officials, elders, and others stepped forward as champions of the vaccine, which was very helpful.

These actions, supported by the government's effort to make vaccine clinics broadly accessible, increased the success of the rollout and the uptake of the vaccine.

Yukoners had a strong sense of community and this was apparent in their desire to access vaccines to reduce their risk to others. Other key factors included early planning for the mass clinic, effective communications, flexibility, and having a vaccine strategy with guiding principles in place. The vaccine strategy had key objectives and underlying principles, including safety, barrier-free access, transparency, fairness, cultural sensitivity and humility, and more. These objectives and principles informed our planning and decision making and were integrated into the training for the vaccine teams.

As mentioned, all nurses completed First Nations 101 and the majority completed the San'yas First Nation cultural safety course. Training also included ensuring that staff understood how to discuss the vaccine with clients, vaccine eligibility, and how to support barrier-free access for vulnerable populations. These efforts were supported through leader training and messaging, supporting de-escalation skills, and having a dedicated clinical lead on-site to support clients and staff.

Finally, the support provided by the federal government regarding the supply of vaccines, guidance documents from the Public Health Agency of Canada, and recommendations on priority populations provided by the National Advisory Committee on Immunization were key factors. Our success was due to hard work, dedication, expertise, and collaboration.

Mr. King: I would just like to add a little bit more, if I could, to DM Boyd's response. A couple of other factors that we felt were important in the success of the rollout of the vaccines were some of the structures that we had in place to communicate with communities. I will just highlight a few of those. We had COVID-19 community leadership calls, which were organized by the Department of Community Services, in coordination with Aboriginal Relations and Health and Social Services. These calls connected the chief medical officer of health with leadership in communities — chiefs, mayors, senior officials with First Nation governments and municipal governments. The meetings provided an opportunity for dialogue, for two-way conversation, questions and answers. In the early part of the pandemic, the meetings were held daily, and that shifted to weekly or as needed as the pandemic progressed.

Another key factor was the Aboriginal Relations community outreach team, which was comprised of liaisons from the Aboriginal Relations unit to act as points of contact for the Government of Yukon between Yukon First Nations, transboundary governments, and the Yukon government. The liaisons helped to ensure that information was flowing between the different levels of government.

The Aboriginal Relations community outreach team worked closely across government and with Community Services as well. They used a very similar model to engage with municipalities and unincorporated leadership to ensure that, as best we could, we were relaying information as it came to light.

There were Yukon First Nation COVID-19 communication calls which were held regularly as well. This was a slightly different focus but with leadership from within government — ministers. First Nation leadership meetings were held as well. The Council of Yukon First Nations met with the Premier, ministers, and leaders within First Nations to share information arising from the pandemic. Those meetings were organized by the Council of Yukon First Nations and attended by Yukon First Nation chiefs.

The Yukon Forum was another avenue during the pandemic for quarterly joint meetings of government and First Nation leadership, providing a space to talk about COVID-19 and the pandemic. Additional things included community liaisons, which I think DM Boyd touched on, and other operational community calls that happened on a regular basis.

Hon. Ms. McLean: I want to just start by thanking all of the deputy ministers, assistant deputy ministers, and public servants for being here today, and to the Office of the Auditor General and to those who are not here today, I think — I take note that, you know, it was a tremendous amount of work that went into the rollout of the COVID-19 response, and it took a lot of dedication to keep Yukoners safe. I have to admit that I feel a bit of an emotional response to listening, to going back in time, that I didn't expect, so I thank you very much for all of the work and your responses.

On page 6, there is ultimately a finding of: "The Department of Health and Social Services, the Department of Community Services, and the Executive Council Office effectively rolled out COVID-19 vaccines in Yukon". There were a number of findings and a recommendation that I will get to. The first set of questions I will have is for the Office of the Auditor General.

There was one finding of outdated and incomplete emergency and pandemic planning. Paragraph 17 of the report states that the Office of the Auditor General "found that emergency and pandemic planning in Yukon was outdated and incomplete." Paragraph 18 notes that sections of the emergency plans were underdeveloped and information was missing. This could leave the government unprepared to fully and effectively respond to emergencies that might arise.

Can you explain which emergency plans were developed in which years? Further, can you explain how they might have left the departments unable to effectively respond to emergencies?

Mr. Hayes: Thank you. Yes, the *Pandemic Health Response Plan* was released by the Department of Health and Social Services in 2009, and a related plan, the *Yukon Government Pandemic Co-ordination Plan*, was released in 2010. Only in 2020 were these government plans updated — after the pandemic started — so that is a decade or a little bit more in between.

We found that the updates were limited, and in our report, we cited the fact that, for example, they were limited to deleting references to H1N1 and adjusting certain appendices. Given how much had changed in the intervening years — for example, technology, relationships with First Nations, and demographics — we concluded that the planning was outdated and incomplete. In addition, in our report, we note that individual department plans were also outdated and incomplete.

The Executive Council Office's most recent plan was dated in 2012, and the plans for the Department of Health and Social Services and the Department of Community Services were both from 2015, so they were also outdated and incomplete.

The fact that these plans were not up to date and were incomplete is a significant finding. For us, these plans need to have up-to-date information on the roles and responsibilities — who to contact and when. In an emergency, it's difficult to expect that people will have the time available to figure things out on the fly. I would note that the Yukon government requires individual departments to develop and implement emergency plans, ensure that they are up to date and exercised regularly. There is nothing that beats running through a mock scenario with the plan to test them. That's why we made the recommendations that we did for updating plans.

Hon. Ms. McLean: If the plans were outdated, how did the government effectively respond to the COVID-19 emergency using those plans?

Ms. Meagher: Despite outdated and incomplete emergency and pandemic plans, we found that, once COVID vaccines were available, the government was able to provide timely access to the vaccines. In December 2020, as you know, the government released a new plan called *Yukon's COVID-19 Vaccine Strategy*, which set out its strategy for safely and efficiently delivering the vaccine to Yukoners. The Department of Health and Social Services also leveraged existing partnerships and the expertise of key stakeholders gained from the annual flu vaccine clinic in Whitehorse, which in 2020 was held in October and November of that year. They modelled the mass COVID-19 vaccine clinic in Whitehorse after that flu clinic. So, using that model, we found that, in our opinion, the mass vaccine clinic in Whitehorse was well-coordinated and -exercised.

Hon. Ms. McLean: As noted already in some of the responses, we note that the plans referenced in the sections were dated either 2015 or 2012, which would seem to suggest that they were fairly recent. How frequently should these plans be reviewed? I know that we have heard some of that, but is there a further answer around that?

Ms. Meagher: The Yukon government emergency coordination plan from 2011 states that departments are responsible for researching, developing, and implementing departmental emergency plans; ensuring that they are up to date, reflective of an all-hazards approach, and are exercised regularly. So, there is a requirement to be up to date, so not to be waiting until the next emergency situation.

We noted in the report and our review of these plans that we found sections were under-developed and information was missing, indicating to us that they were not being kept up to date. This could lead to those departments being unprepared to fully and effectively respond to emergencies that might arise. The frequency of these plans being updated, however you feel, might be a question better directed toward the departments, because it is not specifically laid out in the legislation.

Hon. Ms. McLean: The Auditor General recommended in paragraph 19 that the Department of Health and Social Services, the Department of Community Services, and the Executive Council Office should update their emergency plans so that they complement each other to ensure a prompt and comprehensive response to future health emergencies.

Is there another jurisdiction that you could point to as an example that Yukon could emulate with regard to this recommendation?

Mr. Hayes: Unfortunately, there isn't. Out-of-date emergency plans is something that has been raised in several audits. It is easy to put these plans on the back burner when there are other things pressing in the operations of the departments. I can even say that, in the case of the Office of the Auditor General of Canada, we have some business continuity plans that we let languish for longer than we should have, and it is something that we have appreciated the importance of addressing ourselves, and we have done that over the last few years.

As we stated in our reports, being unprepared to fully respond and have a plan to guide your response is an important matter. Obviously, when we face these unique challenges, learning the lessons from those experiences and implementing them right away is important. The people who have the knowledge because they lived through the scenario might not be the ones who are dealing with the next crisis; so, having up-to-date plans becomes important. Revisiting those plans with developments in technology, demographics, and other things becomes important as well.

Hon. Ms. McLean: In their status-update submission to the Public Accounts Committee on September 28, 2023, that being the departments, the departments have indicated that the Government of Yukon updated its pandemic plan in 2020 to respond to the pandemic.

The Auditor General, however, found that the only changes made to the 2020 version of the *Yukon Government Pandemic Co-ordination Plan*, updated from 2010, were deleting references to the H1N1 virus and adjusting the appendices. This is found in paragraph 17.

Does the Office of the Auditor General feel that these cursory changes meet the recommendation set out in paragraph 19?

Mr. Hayes: Unless the government has done something to its pandemic plan after our report, our findings and conclusions would still stand. I noted that there was a reference in the letter from the deputy ministers in September, but from our perspective, our recommendation in paragraph 19 still needs to be addressed.

I would signal that, with that recommendation, we expect that the departments would deal with each of their individual plans, but in the case of the Department of Health and Social Services, they need also to look at the two broader plans that I mentioned before. The one from 2009 and the other one from 2010 need to be addressed as well.

With respect to the changes made in 2020, again, I would signal that those were very limited. There was an outdated and incomplete plan, and now is the time to fix it. There are valuable lessons that have been learned, and I think the deputy ministers have mentioned a few of them that can be

incorporated into some of the planning. It would put the government in a more advantageous position to face a future emergency.

Hon. Ms. McLean: Moving to the deputy ministers or other officials, how will First Nation governments be engaged in the emergency plan updating?

Mr. King: The Emergency Measures Organization has four emergency planning officers who work within the branch. They are working directly with Yukon First Nation governments on a range of planning and training exercises, including the all-hazards identification plans, emergency plans, and opportunities to exercise those plans through either scenario planning or tabletop exercises.

I look at the work that's happening across the territory, and I see that every First Nation government has been engaged with the Yukon Emergency Measures Organization in one way or another. For example, work is now completed in 2023 to complete hazard identification risk assessments with the Town of the City of Dawson and the Tr'ondëk Hwëch'in First Nation.

Those hazard identification risk assessments help to prioritize and identify the risks to help focus in the emergency plans that follow. That is just one example, but there is work happening across the territory in all communities. Through this work, the Yukon government is also working with the Yukon First Nation governments and municipalities to establish a common emergency management operating system, which is based around the Incident Command System. This includes providing training for the positions that are key for the incident command structure, whether those roles are filled within the emergency coordination centre within the Yukon government or at a community emergency operations centre.

As well, there are plans to engage the First Nation governments directly in the review of the *Civil Emergency Measures Act* and the *Public Health and Safety Act*.

I think I will leave it there for now.

Hon. Ms. McLean: How will municipalities be engaged?

Mr. King: In a similar way, the emergency planning officers within the Yukon Emergency Measures Organization are also working with municipal governments to do the work for the hazard identification risk assessments to support emergency planning and in some cases to support specific plans, such as evacuation plans, and coordinate with municipal governments for training and for tabletop exercises. It is a work in progress across the territory, and all municipalities are engaged in this in one way or another.

One other thing that I can just mention that has directly engaged municipalities and First Nation governments in emergency response was a recent Operation Nanook, where we had really excellent participation from across the Yukon, from First Nation governments and municipal governments, as well as industry and commercial enterprises. That was a really great opportunity to identify some gaps in our emergency plan systems and to strengthen those.

Hon. Ms. McLean: The departments have indicated that they updated their pandemic plan in 2020 but make no reference to the plans noted in paragraph 18 of the audit report. When will the departments update the specific plans referenced in paragraph 18?

Mr. King: I think that the emergency plans that are referenced in that section are to do with the departmental plans, so departmental plans are being led by each department and coordinated with some support through the Emergency Measures Organization. Those plans are being updated, as I understand it, on a fairly regular basis based on lived experience and after-action reviews that may have been relevant for departments, but the main focus for us will be the update of the Yukon government's emergency coordination plan. This is the foundation of the Yukon government's approach to emergency management. It establishes the small emergency response agency — sorry, the Emergency Measures Organization — and details how that group will draw upon staff resources and coordinate responses from across government.

Work is underway to update the Yukon government's civil emergency measures plan. We have, through Community Services, a contractor in place. What is happening right now is an actual gap analysis looking at how we respond versus what is written on paper, which will inform our next steps in that update for that emergency plan.

Mr. Ferbey: I would just like to add to Mr. King's answer. In the Premier's 2021 mandate letter for the Executive Council Office, we were tasked with evaluating Yukon's COVID-19 pandemic response once the state of emergency was lifted. The Executive Council Office has been working with the departments on this report and will incorporate Yukon-based research, including through the COVID-19 recovery research program, and insights from other jurisdictions. The report will also benefit from the work of the Auditor General and the Yukon government's progress in response to the recommendations.

The health and wellness of Yukoners is the primary concern. We are steadfast in our mission to continuously learn, improve, and serve Yukoners better. I want to reiterate the Government of Yukon's thanks and appreciation to the front-line workers who stepped up during the pandemic to keep Yukoners safe and manage the impacts of COVID-19. We look forward to sharing the report once it is completed.

Ms. Boyd: Health and Social Services has completed a number of after-action review exercises within the department, including targeted staff surveys and debrief sessions for the impacted program areas responsible for meeting pandemic objectives, such as vaccination and case management. We have also completed a pandemic recovery and resilience self-assessment exercise, supported by Health Excellence Canada. The next step for us is to use this information to inform the pandemic sections of a new emergency response plan to inform decisions on resource allocation and priorities for system improvement and to identify priorities for operational planning and system changes.

Specific information will be included in the appropriate chapters, including vaccine rollout, case management, testing, public partner and stakeholder communications. This work will address more than just the vaccine campaign, as we want to be sure we are addressing all of the lessons learned during the

pandemic. Very specifically, in response to that question, the HSS departmental emergency management plan is currently under review and will be fully updated by December 2024.

Hon. Ms. McLean: The departments have indicated in their submission to the Committee that the Government of Yukon's emergency plan will be updated with lessons learned from the pandemic alongside this review. I note that some of this may have been answered, but I will just ask the questions anyway.

We wanted to know what emergency plan is being referred to here, and when will this update occur?

Mr. King: The emergency plan referred to here is the Yukon government's emergency coordination plan, as well as the pandemic plan, which was updated in 2020.

The emergency coordination plan, as I touched on before, is the foundation for our approach to emergency management, and that is where our focus is lying right now in terms of updating for government-wide coordination.

Hon. Ms. McLean: When will this update occur?

Mr. King: The update is underway. We expect it to be completed in 2024. It will likely take until summer 2024 to complete the plan.

Hon. Ms. McLean: How frequently will departmental emergency plans be updated and reviewed going forward?

Mr. King: Departmental emergency plans — the approach we would like to take is to review them on a regular basis. I know that isn't a specific timeline, but basically, we will incorporate the lessons learned from after-action reviews into those plans and — within Community Services, anyway — build it into the business cycle of managing our operating plans.

As a general rule, I suppose, we would likely put in a five-year review period, which would be required for all plans.

Mr. Kent: The first couple of questions I have are for the Auditor General, and they are in regard to the quick development of a strategy to roll out vaccines.

Paragraph 20 notes that the Department of Health and Social Services collaborated with the Department of Community Services and the Executive Council Office to provide timely access to vaccines in Yukon. Further, paragraph 21 describes how the Department of Health and Social Services used the 2020 flu clinic to model a COVID-19 vaccine rollout, leveraging existing partnerships and expertise. Again, for the OAG, how would you assess this dry run, and did it ultimately lead to a more successful vaccine rollout?

Mr. Hayes: We did not audit or assess the 2020 flu clinic specifically, but what we did find was that the magnitude of the flu clinic, which involved vaccinating 14,000 Yukoners over a six-week period, did give the Department of Health and Social Services the ability to leverage that experience and the existing partnerships and expertise of key stakeholders, which it used to model the COVID-19 vaccinations. From our perspective, this is something that the department should be commended for. Learning lessons and applying them is very important. Our audit recommendations are really geared toward building on that. There are lessons that can be learned and opportunities for improvement. Again, the department should be commended.

Mr. Kent: As noted in paragraph 22, in December 2020, the Government of Yukon released its COVID-19 vaccine strategy. Again, for the Office of the Auditor General, can you provide an overview and assessment of the 2020 COVID-19 vaccine strategy?

Ms. Meagher: We found that the strategy was important in rolling out vaccines, setting out the objectives and actions to be taken to achieve those objectives, and making commitments in a transparent manner. For example, the Department of Health and Social Services prioritized administering the initial vaccine dose to the most vulnerable populations in the territory. It set out the establishment of vaccine clinics, worked to reduce barriers to access the vaccines, and monitored and reported on progress. However, we did identify some issues, such as some vulnerable residents facing barriers to getting vaccinated. We also noted some insufficient collaboration with First Nations, in particular in planning the vaccine rollout. We also found inefficient manual systems to monitor inventory and waste.

However, that being said, we feel that overall vaccinations were timely and accessible.

Mr. Kent: Mr. Chair, moving on to vaccination prioritization following federal guidance, the audit report mentions in paragraph 23 that the Department of Health and Social Services used guidance from Canada's National Advisory Committee on Immunization to prioritize key populations for the COVID-19 vaccine rollout.

Again, for the Auditor General, can you explain why following the National Advisory Committee on Immunization's guidelines were important for Yukon?

Mr. Hayes: The National Advisory Committee on Immunization is made up of experts, including people in the fields of immunization, infectious diseases, and epidemiology. That committee exists to provide guidance on the use of vaccines, and it has technical expertise not necessarily available to individual jurisdictions across the country. The Department of Health and Social Services relied on the guidance from this committee in making decisions on how to prioritize the administration of the vaccines.

I would also note that the department consulted with the territory's chief medical officer of health given the risk, logistical, and epidemiological concerns specific to the territory. This includes things like transporting and administering the vaccines in Yukon. To us, this actually represented a thoughtful and deliberate approach to prioritization.

Mr. Kent: Thank you. Paragraph 24 states that the Office of the Auditor General found that the Department of Health and Social Services prioritized administering the initial vaccine dose to the most vulnerable populations in Yukon. Then, quoting from paragraph 25, the OAG: "… found that the Department of Health and Social Services vaccinated clients and staff of some organizations providing services to higher-risk populations before others providing similar services. Some of these services are provided in locations where physical distancing and other infection prevention and control measures are challenging. These types of settings put those working and living in them at a higher risk of becoming infected."

For the Auditor General, did the auditor receive any context for why these locations were used? How many of these sites were identified, and were they in Whitehorse or rural Yukon?

Ms. Meagher: Thanks. As part of our audit, we interviewed representatives from several organizations providing services to whom we felt were higher risk populations. We conducted these interviews in confidence. These organizations were all located in Whitehorse. Our intent here was to highlight that it would be important for the Department of Health and Social Services to ensure that it is consistent in its prioritization in offering vaccinations to staff in organizations that provide similar services and face comparable risks of infection. Consistency would help to ensure that the clients and staff of these organizations are given consideration in the prioritization of the vaccine rollout.

Mr. Kent: So, again, for the Auditor General, as part of your audit to help improve government planning, did you provide the department with the locations of these sites, recognizing the confidentiality aspect that you just spoke about as well?

Ms. Meagher: No. We did make the department aware that we were conducting these interviews, but we did not disclose to them which organizations the team had interviewed so as to maintain confidentiality and to facilitate open and transparent conditions for interviewing these organizations.

Mr. Kent: So, for the department officials who are here today, how many locations were selected and how were these sites chosen? And if you are able, please provide whether they were in Whitehorse or rural Yukon.

Ms. Boyd: In Whitehorse, we initially prioritized a number of settings and populations based upon risk of transmission and severe outcomes due to the infection following both the National Advisory Committee on Immunization guidance and technical expertise offered by the department and the chief medical officer of health. These locations included long-term care residents in Whitehorse and Dawson City, followed by 405 Alexander and the Whitehorse Correctional Centre. These decisions were made due to the nature of the populations, their living situations, and their ability to access the mass clinic. In other settings, clients were transported with staff supports to access the clinic.

It is important to note that, when the vaccine was first released, there were very strict guidelines on handling the vaccine and the ability to transport it to different sites. This impacted our training requirements for staff and where it could be offered. Over time, the manufacturer changed these protocols, as evidence supported less stringent requirements for the handling and transportation of the vaccine. Later on, as vaccine stability and transportation restrictions loosened, sites at Kwanlin Dün First Nation were supported, as well as pop-up clinics at the Kwanlin Dün Cultural Centre in partnership with the Yukon Anti-Poverty Coalition and organizations such as the Fetal Alcohol Syndrome Society Yukon.

Unfortunately, not all were considered successful, given the number of vaccines delivered and the impact that it had on reducing services at the mass clinic.

The mobile teams provided vaccines via multiple sites to communities. It is also important to note that the specific requirements to respond in the future will change depending on a number of factors. In the future, our response to infectious disease emergencies will need to consider the type of infectious agent and how is it is transmitted, who is at risk of the serious disease, and the effectiveness of the vaccines and treatment.

Mr. Kent: Paragraph 26 notes that staff from a number of organizations told the OAG there was a lack of clarity about which clients and employees would be prioritized by the Department of Health and Social Services. They did not understand why their organizations had not been prioritized. They were concerned that, given the risks they faced, they should have been eligible to be vaccinated at the same time as prioritized organizations providing similar services.

I have a couple of questions for the Office of the Auditor General: Which organizations, staff, and volunteers did the auditors speak to, and was the full data provided to the departments? Again, just with the caveat that there may be some confidentiality issues that you flagged earlier that may apply here as well.

Ms. Meagher: As mentioned in the last question, we interviewed several representatives from many organizations that we considered to be high-risk populations. They were all located in Whitehorse; however, we conducted these interviews in confidence to encourage candid discussions. As such, we can't mention the names of those organizations specifically. Also, for future audits, if we want to continue to have that relationship with third parties, we don't want to be telling them one thing and then having a surprise at the end.

In terms of the data that was provided to departments, again, we did inform them that we were interviewing organizations that were stakeholders. We did not give specifically the names of the organizations to the Department of Health and Social Services. That being said, it's not uncommon for us, as part of our audit work, to speak with stakeholders and other groups who wish to remain anonymous, but we can note themes and trends that do come out. We do share that information with the departments, and we can — and do — often present our findings in our report.

Hon. Mr. Mostyn: I would like to welcome the auditors and the officials to the Chamber this afternoon. I want to begin, just very quickly, by thanking the Yukon civil service, first responders, First Nations, and citizens for the nation-leading response to the pandemic here in the territory.

Yukoners deployed this vaccine through some of the most formidable geography and weather in the country and faster than most jurisdictions. Moderna was approved on December 23, 2020 — that's my birthday — and we got it in arms 11 days later. That's truly remarkable. I really want to acknowledge that and thank the folks who were responsible for that response — some of whom are in the room this afternoon.

In paragraph 27, the report describes how the Whitehorse Emergency Shelter was identified as a prioritized organization, with a vaccination clinic held on January 25, 2021, but other organizations in Whitehorse providing services similar to those of the emergency shelter had to wait to be vaccinated until the

mass vaccination clinic opened to the general public on March 1, 2021, and no additional clinics were set up specifically for these organizations.

This is a question for the OAG: Could vaccine scarcity account for the fact that additional clinics were not established for some priority staff who were passed over in the beginning? As a follow-up, could a lack of prioritization have led to problems?

Mr. Hayes: We found that there was a sufficient supply of vaccine doses and clinical supplies, so I don't think that vaccine scarcity would account for the fact that additional clinics were not established for those priority staff. What we found was that there was a difference in the way that people were treated depending on what place they were finding themselves in. So, while the department says that avoiding wastage was part of the reason why staff in some clinics were able to be immunized, the reality is that comparable circumstances could have existed in the other places that we are talking about.

The issue, as we stated in paragraph 29 — and the recommendation in paragraph 29 is that the department should ensure that organizations that are providing similar services and facing comparable risks of infection should be treated in an equivalent manner and that prioritization decisions should be included in emergency planning documents. Basically, we're getting at the point of transparency and fairness.

Hon. Mr. Mostyn: For the deputies or the officials in the room, can you tell us whether vaccine scarcity played a role in additional clinics not being established for organizations providing services similar to those of the emergency shelter? Again, could a lack of prioritization have led to problems?

Ms. Boyd: Mr. Chair, as noted previously, when the vaccine was first released, there were very strict guidelines on handling the vaccine and the ability to transport it to different sites, including the use of special shipping containers and procedures required to keep the products below minus 20 until use. Initially, punctured vials and vaccine and syringes could not be transported. This impacted significantly where clinics could be offered. In addition, the focus was on getting the population vaccinated quickly in the most expedient manner to reduce illness, death, and the impact of COVID-19 on a strained health system.

Minimizing dose wastage was definitely a consideration, as Yukon was privileged to receive a full allocation of the vaccine during the first three months of 2021. At the same time, provinces were incredibly desperate for as many doses as they could get. Each vial contained 10 doses and, once punctured, had to be used within six hours, after which the vial had to be wasted. So, it was important to have enough arms ready or scheduled for every vial opened. Front-line staff worked hard to make decisions in the moment to ensure that every dose in the time-limited punctured vial was used on-site and not discarded.

In addition to the transportation challenges, off-site storage conditions needed to be considered as well. Specialized freezers were required and limited in number. There were also thawing timing requirements prior to administration of the vaccine. This required planning, as there was a specific thawing time. Once thawed, as I have shared, there is a limited time frame to use the doses. There were also safety considerations, as we needed to ensure social distancing at any potential vaccination site.

Finally but very importantly, we had a limited number of vaccinators who were in demand throughout the country. Because we were in a state of emergency, we were able to recruit other health professionals to help vaccinate. We recruited physicians, pharmacists, nurse practitioners, registered nurses, and licensed practical nurses from all available departments, our hospitals, and from the Red Cross. Yukon paramedics also played an incredibly important role at our clinics. However, finding enough vaccinators to provide continuous access to services was an ongoing challenge. To get as many people vaccinated as quickly as possible, we needed to ensure that this limited supply of vaccinators was used in the most efficient way possible. When deciding on whether to establish a satellite location, we had to weigh all of these important considerations.

Hon. Mr. Mostyn: The Auditor General made the following recommendation in paragraph 29: "The Department of Health and Social Services should ensure that organizations providing similar services and facing comparable risks of infection should be prioritized for vaccination in an equivalent manner. This prioritization should be included in emergency planning documentation."

For the officials, what departmental planning documentation are the departments referring to in their response to this recommendation in paragraph 29 of the audit report?

Ms. Boyd: Thanks. This is referring to the internal prioritization framework using the NACI guidelines adapted to Yukon using population geography and local health resources. We appreciate that certain front-line workers thought that they should be prioritized to get a vaccine, and based on scientific risk analysis, they were not considered to be high risk. Unfortunately, we did not clearly communicate the risk-based criteria that was used, which resulted in some confusion among health care workers believing that they were at high risk and therefore eligible for early vaccination.

When vaccine was scarce, it was only those front-line workers who could not avoid close contact or adequately protect themselves from risk of transmission who were eligible. By that point in the pandemic, we had adequate supplies of PPE throughout the territory to protect workers. In settings where the nature of the interaction between health care worker and client posed little risk of transmission, it was not necessary to prioritize those workers. We did not adequately communicate this and, as the OAG suggests, document this so risk criteria used could have been explained to those with questions.

Health and Social Services is currently reviewing our process to identify and communicate with target populations selected for early vaccination during a pandemic. While the process can be improved, the content will need to be developed to the specific circumstances we find ourselves in. Again, this will change dependent on the specific virus, how it is

transmitted, and what specific populations are most vulnerable. This work is underway and being conducted by the Community Health Programs team within the department and will be outlined in updates to emergency response plans.

Hon. Mr. Mostyn: How and when will this work occur?

Ms. Boyd: Health and Social Services is currently reviewing our process to identify and communicate with target populations selected for early vaccination during a pandemic. Again, this work is underway and being conducted by the Community Health Programs team within the department and will be outlined in updates to the emergency response plans. As mentioned earlier, we are also updating our departmental emergency response plan. That work is expected to be complete by December 2024.

Hon. Mr. Mostyn: I am now going to turn to effective rollout of clinics and timely vaccinations as a subject.

Paragraph 31 of the report describes how the Department of Health and Social Services assembled five multidisciplinary teams to coordinate and administer the vaccine rollout.

For the Auditor General, was this multidisciplinary approach effective?

Ms. Meagher: Yes, we found it was effective. We found that this approach allowed the Department of Health and Social Services to coordinate and administer the vaccine rollout effectively and provide timely vaccinations.

The model was designed to minimize the number of different delivery sites, the use of human resources efficiently, and respect the limitation of the stability and mobility of the vaccines, such as temperature control, transportation, and storage.

Hon. Mr. Mostyn: The report states, in paragraph 36: "By 6 November 2022, 81% of the population of Yukon had received 2 doses and its vaccination status was comparable to the rest of Canada…"

For the Auditor General, can you describe the vaccine rollout in Yukon compared to the rest of Canada and, secondly, specifically in reference to Exhibit 5, the chart on page 12?

Mr. Hayes: The three territories were prioritized to receive vaccines that had less extreme transport and storage requirements. This was a recognition by the federal, provincial, and territorial governments of the territories' remote communities and large Indigenous populations. While we didn't compare Yukon's performance against the rest of Canada, we note that, on December 28, 2020, Yukon received its first shipment of vaccine doses and that, on January 4, 2021, vaccinations began in the territory, starting with long-term care residents in Whitehorse. We found that the vaccination rollout was timely, and the Yukon government should be applauded for this.

Exhibit 5 that we have in our report shows that the Yukon's vaccine coverage was comparable to the country overall, through two doses and two boosters. You will see in that exhibit that fewer people were seeking the vaccine as time went on. That was a consistent reality across the country.

Hon. Mr. Mostyn: Thank you for that answer. My next question, actually, is for both officials and for the Auditor General, so I will ask the Auditor General first. What key factors contributed to the high vaccination rates in the Yukon compared to Canada nationally?

Mr. Hayes: In addition to the effective rollout of the clinics, we found that there was information available to the public on when and where to be vaccinated. This was provided through the Government of Yukon's website, radio, and television advertisements. There were posters, social media, a telephone line, news conferences, and other abilities to talk to officials. That said, our report signals the need for improvement in terms of collaborating meaningfully with First Nations.

Ms. Boyd: Knowing that our full allocation was coming, even though we didn't know exact quantities or shipment dates, was essential for our planning and for the rollout. Other important factors were effective communications and public trust. We communicated in a variety of ways through social media, advertising, posters, and print materials and directly to community leaders. Having the support of elected officials was important not only to deliver the program but to build public trust. First Nation and community leaders championing the vaccine and providing consistent and reliable information to their citizens and members was invaluable.

We certainly recognize and are committed to improve our communications and our work on cultural safety as well in that regard. The CMOH and the Premier were open and transparent during their many, many media briefings, which helped to respond to the views of folks who had opposing views and to address concerns.

Finally, the reason that we led the country for many months in our vaccination rates was thanks in large part to Yukoners. Yukoners from every part of the territory not only lined up to get their shot, but they encouraged and helped family, friends, communities, and neighbours to get their immunizations as well.

Communities provided rides, snacks, and encouraged whatever initiatives they could to support individuals to get to clinics. From the government's perspective, it was an amazing team effort that required a lot of personal sacrifice and hard work. We also recognize and thank Yukoners for trusting us to do our part and for doing their part. In the end, everyone's efforts literally saved lives and was demonstrated in our per capita rates of death, which were among the lowest in the country and considerably lower than our closest neighbour, the United States.

Hon. Mr. Mostyn: Thank you very much, and for my final question this afternoon regarding territory-wide communications planning and monitoring, the Office of the Auditor General found that information was available to the public on when and where to be vaccinated. Paragraph 39 notes: "However, the department was unable to provide [the auditors] with complete communications plans and monitoring and tracking tools. In [the Office of the Auditor General's] view, it is important for plans to be complete and to track their implementation in order to know if communication has been effective."

For the Office of the Auditor General: What communication plans and tracking tools should have been used? What factors did you consider in your audit of this area?

Mr. Hayes: So, it is up to the government to determine the plans and tracking tools that should be used, and of course, these are going to be — or should be — tailored to the precise situation that the government is facing. Our view is that it is important for plans to be complete and to track their implementation in order to know if communication has been effective.

If for some reason certain communication activities are not effective or maybe not as effective as one had planned them to be, the government needs to identify this and adjust so that they can make sure that they reach their intended audiences.

Chair: The next few questions will be from me.

The Office of the Auditor General reported, in paragraph 42, that the Department of Health and Social Services and the Department of Community Services made efforts to lift barriers at clinics. For example, they made special accommodations for individuals with autism or allergies, accepted non-residents of Yukon, such as members of First Nations outside the territory's borders, and over time established workarounds for Yukoners without a health care card.

To government officials, when you learned of gaps in service, how did you address those issues?

Ms. Boyd: Blocks of appointments were held for vulnerable population groups, ensuring that staff they knew would be on-site to ease their fears. Examples included KDFN elders and vulnerable populations, group homes, FASSY, special needs adults and children. There was a private area set up in the back of the clinic to support those who required more privacy and included a place to lie down to receive the vaccine. Blocks of appointments were set aside at the Whitehorse Health Centre to support children with autism or others with special needs or overwhelming fears. People whose physicians felt that they were at high risk of an anaphylactic reaction were vaccinated in the emergency room at the Yukon hospital, and supports were readily present, if required.

Also of significant importance, we handled numerous individual requests for people facing barriers. For example, many special accommodations were made for access for those who had to travel out-of-territory for medical reasons, like cancer treatments or humanitarian relief workers. We also quickly established a policy allowing those people waiting for health care cards to be vaccinated.

Finally, we also took vaccines directly to people living in long-term care homes, to 405 Alexander, and to the Whitehorse Correctional Centre. We are very proud of the work we did to reduce barriers. It was one of our vaccine strategy's primary objectives and one that, through a lot of hard work, compassion, and flexibility, we accomplished.

Chair: Quoting paragraph 44 of the Auditor General's report: "Some community representatives told…" — the Office of the Auditor General — "… that the logistical plans for mobile vaccine clinics were not always well communicated to community leaders. For example, Government of Yukon staff sometimes first contacted managers of locations such as gyms and recreational centres instead of the municipal mayors or First Nations leaders to arrange the logistics for the vaccination clinics. The departments did not use the territory's emergency and pandemic planning framework for the vaccine rollout." The audit "… found that even if they had used the framework, it specifies only that appropriate parties should be kept informed — it does not specify which parties should be the necessary points of contact."

To the Auditor General: Can you please provide context on the number and source of the concerns identified in paragraph 44?

Mr. Hayes: We spoke to community representatives across the territory, and the concerns that we have signalled in the report were messages that we heard frequently enough to warrant including them in our report.

We pointed out that the departments did not use the territory's emergency and pandemic planning framework, and we did note, of course, that the framework only specified that appropriate parties should be kept informed. It doesn't specify which parties should be the necessary points of contact. This takes us back to our conclusions and recommendations that emergency and pandemic planning was out of date, and we recommended that the departments update those plans so that they compliment each other and ensure a prompt and comprehensive response to future health emergencies.

Chair: The audit found, in paragraph 44, that the departments did not use the territory's emergency and pandemic planning framework for the vaccine rollout.

Can you please explain this and why this was not subjected to a recommendation?

Mr. Hayes: We pointed to a weakness with the plan, and in paragraph 44 in particular, the plan does not say who should be informed. This is not very helpful in an emergency. As for the recommendation, we did recommend that the government needs to update its plans and to keep them updated. In our view, it should also be clear that departments should follow their updated plans as well.

Chair: The Auditor General recommended, in paragraph 45 — quote: "For future vaccine rollouts, the Department of Health and Social Services and the Department of Community Services should provide and communicate alternatives to online and phone options for booking services that are as barrier-free as possible."

To government officials, what communication options are the departments considering? Have you looked to other jurisdictions to see other options?

Ms. Boyd: Finding alternatives to online and phone options when you are dealing with a highly communicable disease is challenging. Reducing opportunities for transmission was an ongoing priority, so any of the typical face-to-face options were not recommended during the pandemic. We also needed to control the flow of numbers of people accessing services at any time to support the safety of clients and providers, which required infection control measures. We also needed to consider available staffing levels, which impacted the number of people who could be provided service and the throughput each hour each day. All of these things factor into what is available with respect to what other measures are possible. This is an ongoing challenge, as we needed to ensure that there were enough doses for the most vulnerable

populations. As a result, at the beginning of the vaccine campaign, we couldn't open the clinic in Whitehorse to walk-ins.

Meticulous calculations for a variety of scenarios had been done on the throughput at the clinic, based on available resources. These were compared to population demographics and eligibility criteria, and each day was planned to ensure the maximum throughput to support and opening walk-ins, as an alternative. That being said, we did accommodate walk-ins who were eligible, based on age or health condition, as much as we could. However, given the supply and safety concerns, we chose not to advertise walk-ins during the first few weeks of our Whitehorse clinic; the risk was just too great. At that point in time, we needed to minimize transmission and protect the very limited and uncertain supply. During our community visits, we did accommodate walk-ins right from the beginning, as people living outside of Whitehorse were all considered high-risk — the unfortunate proof of that being the incident in Beaver Creek, which I am sure that folks remember, where two folks from Vancouver posed as motel workers and were vaccinated.

This attests to the fact that we were flexible and that telephone or online appointments are not always the only way to get vaccinated. To encourage people without phones or Internet access, First Nation community leaders were informed of vaccination schedules and locations directly through government-organized calls and government liaison workers. This continues to be a strength that we have leveraged for the department and are continuing to build on and have looked at how we can actually create alternate roles within the Department of Health and Social Services to build on relationships in communities, which is also a culturally safe practice to look at how we can leverage folks who actually go and support people to access appointments directly, when appropriate.

Local and visiting teams in communities were creative in finding transportation to get people to the clinics. This was critical. We also communicated these schedules directly via news conferences, radio spots, print advertising, posters, and social media campaigns. These products were leveraged by NGOs, First Nation governments, and health care and community partners. The best alternative to phone or online bookings that we have found so far is the ability to accommodate walk-ins, but that is not quite as easy as it may seem. This is an issue that we will continue to consider, as the goal is to provide vaccines to as many people as you can, regardless of their circumstance. This is also something that we have brought forward into our work as we progress — any work that we do with respect to advancing health in the digital fields, embodying this concept of digital health equity, and ensuring that we remain accessible to all folks and Yukoners.

Chair: Okay, the following questions are for government officials regarding staffing vaccination clinics and cultural sensitivity. Paragraph 46 of the Auditor General's report states: "Given that the COVID-19 pandemic extended over a long period of time, demands on vaccination staff were considerable." Paragraph 47 details the training that needed to be provided to immunizers.

So, the question: How many people were responsible for planning the vaccination program?

Ms. Boyd: Planning began well before we knew when or what type of vaccine was arriving in the Yukon and continued throughout the campaign. Many different people are involved to different degrees in the planning. For example, we have a small team who initially developed the vaccine strategy; a team who focused on vaccine supply and handling; and another group who planned the mass flu clinic, which acted as a prototype for the Whitehorse COVID-19 vaccination clinic.

There was a core group of people at the Department of Health and Social Services of approximately 20 employees who ultimately planned all operational aspects of the actual vaccination program. This included plans of vaccine handling, transportation, and storage; immunizer training; vaccine administration; vaccine prioritization, determination, and modeling; community scheduling; and human resource scheduling.

Chair: How long did planners have from the time of the flu clinic to the arrival of the first vaccines?

Ms. Boyd: Instead of moving between multiple locations as in previous years, we set up the 2020 mass flu clinic at a centralized location. It was intentionally set up as a trial run for the mass COVID-19 vaccine clinic, and its design and operation were based upon Public Health Agency of Canada standards. Planning for the mass flu clinic started in June 2020 and continued through that fall. The mass flu clinic opened in October and closed on December 3. The mass flu clinic dry run allowed for planners to tweak the preparations and test throughput calculations, which proved to be accurate.

There was one month between the closure of the flu clinic and the delivery of the first COVID-19 vaccine doses. The first vaccines arrived in the territory on December 28, and the first vaccination occurred on January 4.

Chair: How long did planners have between learning the specific properties of the first vaccine coming to the Yukon to delivery of said vaccine to train vaccinators and staff in the proper handling and transport, storage, and professional technique to vaccinate Yukoners?

Ms. Boyd: Thank you for asking this question, as many folks don't always appreciate or recognize what a challenge and truly remarkable accomplishment this was.

Health Canada authorized the Moderna vaccine on December 23, 2020. This is when we first learned all the precise details about proper handling, transport, storage, and delivery. We did have advance information sometime in November that these new vaccines were not stable and would require special handling. This is why we were sourcing the necessary freezers from the federal suppliers prior to knowing exactly what was going to be needed.

The clinical guidance was only available once Health Canada formally approved the vaccine and issued product monographs on December 23. Recommendations from the National Advisory Committee on Immunization on who should get the vaccine first were also issued on December 23. The

Yukon received its first shipment, as I just shared, of the Moderna vaccine on December 28. That gave us a total of five days over Christmas between getting this essential information and when the first batch of vaccines arrived in the territory. During this time, training materials were developed, priority populations were identified, and rollout plans were finalized based on the initial allocation of 6,400 doses.

We began putting needles in arms on January 4, which required staff to undergo training for the safe handling and administration of the vaccine over the holiday period. On January 7, we published our rollout schedule, which identified the schedule for priority populations and rollouts to the communities. We identified the priority populations based on a limited quantity that we received and developed and implemented all of the protocols needed for training, storage, and transportation.

We also conducted a dry run for our mobile teams before they arrived in communities on January 18. While the overall quantity of vaccine for the first quarter of 2021 was promised by Canada, the arrival dates and specific quantities expected on those dates were in constant flux, with Canada only providing two- to four-week confirmation. This required prioritization of decisions and rollout schedules to be both flexible and exceedingly challenging to determine.

Finally, it's also important to remember that this required new knowledge, new protocols, and new training, as we were dealing with a new type of vaccine — the very first mRNA vaccine to be brought to market. It was a remarkable accomplishment by a small team of dedicated professionals — all accomplished over the Christmas holidays. I can't express enough how much we owe them a great deal of gratitude for the success of the vaccination campaign and for saving lives.

Ms. White: We are moving on to the section that is entitled "The departments did not effectively collaborate and communicate with Yukon First Nations" and the subheading "Insufficient collaboration with Yukon First Nations in planning vaccine rollout".

Quoting from paragraph 54, the Office of the Auditor General "… found that Yukon First Nations were not involved in pandemic and emergency planning, nor were they given the opportunity to provide input on Yukon's COVID-19 Vaccine Strategy, which was made public on 10 December 2020." The auditors "… also found that First Nations were briefed late in the planning of the vaccine rollout and had limited input throughout its implementation."

My question for the OAG: What is the data that supports the findings in paragraph 54?

Mr. Hayes: We found that First Nations and community leaders were only informed in January 2021 of vaccine schedules and locations. This was done on tight deadlines and with limited dialogue.

Months had passed between when the government first declared a state of emergency in March 2020 and when the vaccines arrived in December 2020. There was, in our view, time to meaningfully collaborate with First Nations and receive their input, including on how communications would be managed, potential barriers their communities could face, and issues regarding vaccine hesitancy.

We actually examined one of the mechanisms that could have been used to support better collaboration — in particular, the Yukon Forum — and a review of the meetings over the period of February 2020 to June 2022 found that it was not used for this purpose. Ultimately, we recommended that the departments should partner with First Nations to outline the level and frequency of collaboration during emergencies. Again, bringing it back to the emergency plans, they can reflect clear roles and responsibilities and the time of communications during an emergency situation. This is an opportunity to build on lessons learned.

Hon. Ms. McLean: Moving on with a similar topic, there was a finding of inadequate sharing of information with First Nations and rural communities. Paragraph 60 states that the Office of the Auditor General — quote: "… found that the responsible departments did not discuss the collection and sharing of data with First Nations as part of emergency and pandemic planning. During the pandemic, the departments received requests from some First Nations for COVID-19 data related to their own citizens."

The Office of the Auditor General — for context, could the auditors provide some detail about the nature of the COVID-19 data requested by First Nations about their citizens?

Ms. Meagher: For a couple of examples, the vaccination rates and the number of COVID cases for specific communities — this information was instead shared at the regional level, amalgamating the results for multiple communities. This made it difficult for residents to determine the vaccination rates and the extent of infection in their own communities, which would be disconcerting for some. However, information by community eventually was shared by May 2021.

Mr. Hayes: I will give another example as well. There could be adverse effects from specific vaccines that were experienced by community members, and that could be a piece of information that might be important for First Nations to know about their citizens.

Hon. Ms. McLean: Again, for the Auditor General, are the auditors aware of any legal restrictions on how information could be shared with First Nations?

Mr. Hayes: The Department of Health and Social Services told us that it did not collect information on First Nation status because of privacy reasons and because it did not want to create hesitancy among First Nation members who might have considered it to be stigmatizing. To us, this illustrates the importance of engaging with First Nations early to discuss how to communicate and break down potential barriers. Building trust is important, and it is more likely that individuals will be feeling comfortable to voluntarily share or to consent to the use of their information where there is a relationship of trust.

Hon. Ms. McLean: Thank you. To the department officials: Were there any legal restrictions on how information could be shared?

Ms. Boyd: Yes, there are legal restrictions related to privacy to consider. The Yukon's *Health Information Privacy and Management Act*, known as HIPMA, sets out the rules about how we can collect, use, and disclose personal health information.

HIPMA only allows for non-identifying information to be released to the public and defines identifying information as "… information that identifies the individual or that it is reasonable to believe could be used, either alone or with other information, to identify the individual…"

This means that, even with data-sharing agreements, such as the one that we have with the Kwanlin Dün First Nation, we cannot release information back to a First Nation that is potentially identifiable. First Nation governments would need to be deemed custodians, agents, or authorized users under HIPMA's Yukon health information network regulation in order to share identifiable information with them. This comes with specific regulatory requirements, including demonstrated privacy and security safeguards, which would require a considerable investment of resources on the part of First Nation governments.

To make First Nation governments custodians under HIPMA, either changes to the legislation are required or a detailed information-sharing agreement, which includes privacy and security requirements under HIPMA, would need to be created and approved by the Information and Privacy Commissioner. This issue is being examined as part of the HIPMA review, and further policy analysis is needed. That said, we can still have effective data-sharing agreements with First Nations — agreements that still protect individual privacy but at times, due to small population sizes, limits some information that can be shared. Though it is not a legal restriction, data on specific Yukon First Nation citizenship is not collected in Yukon's electronic systems that track reportable diseases, including COVID-19 and immunizations.

We are also doing work to establish good data governance with First Nations that would align with the principles of ownership, control, access, and possession — known as OCAP — to the greatest extent possible.

Mr. Kent: Turning our attention to paragraph 65, the Auditor General recommended that the Department of Health and Social Services, with the support of the Executive Council Office, should work with First Nations toward finalizing data-sharing protocols or agreements to meet the needs of the First Nations. So, my questions are directed to the departmental officials who are here today. I will combine them, though.

How is this being addressed, and how does it include all First Nations in the Yukon, and was there any involvement with transboundary First Nations, due to their proximity and some who were included in the vaccine rollout?

Ms. Boyd: Collecting Indigenous data often has been a contentious and challenging prospect given the history of colonialism, systemic racism, self-government agreements, and the principles of First Nation ownership, control, access, and possession, known as OCAP. Many First Nations, for very reasonable reasons, are reluctant to see Crown governments hold their data.

That being said, if it is done right, it can be done. We are offering to work with Yukon First Nations to address their concerns and ensure that their data is protected. An updated information-sharing agreement, which is the second of two with Kwanlin Dün First Nation, has recently been signed by the chief and the Minister of Health and Social Services. This updated agreement meets a broader scope to replace the existing agreement with specific COVID-related health statistics. Seasonal COVID-19 and influenza vaccination coverage disaggregated by community is also published.

The absence of data-sharing agreements does not preclude the department sharing data in accordance with privacy legislation. In some cases, data disaggregated by community, rather than by First Nation citizenship, can meet the needs of First Nation governments. For example, recently, the department responded to a data request from the Champagne and Aishihik First Nations chief for data disaggregated by specific postal codes corresponding to Haines Junction, Takhini, and Champagne. Another example of our work to share First Nation-specific data is the Yukon First Nation cancer care project. The project team is working on options to produce Yukon First Nation-specific cancer data. Currently, an agreement with Statistics Canada is being explored to link the Yukon cancer registry to census data.

Other options for data linkages have been proposed, including linking First Nation citizens lists — our Health and Social Services administrative data — to cancer registry data, but these options have not received approval from First Nations. We are working actively with the data-governance team at the Council of Yukon First Nations to progress data-governance priorities as it relates to the Yukon First Nation data. We anticipate taking this topic of data collection-sharing to an upcoming Health and Social Development Commission meeting.

In summary, to the first question, data sharing is more complex than it might appear. We are very willing to enter into customized data-sharing agreements and respect and honour the concept of data sovereignty for First Nations and want to ensure that we meet individual First Nation needs.

Mr. Kent: Again, just to circle back — and I apologize to Ms. Boyd if she answered this — but was there any involvement with transboundary First Nations? The next question I have is: Have there been any data-sharing protocols or agreements established with First Nation governments so far? Perhaps one was mentioned in that previous response.

Ms. Boyd: The Yukon has a formal memorandum of understanding with BC for the provision of public health activities for Lower Post, including the administration of vaccines. Residents of Lower Post were eligible for vaccinations at clinics held in Watson Lake, as well as clinics organized at the Lower Post health centre. Vaccines were also supplied to Atlin, BC area residents using Yukon's established vaccine products supply chain.

We negotiated with Canada so that our vaccine allotment included those communities. Where we administered the vaccine, our staff entered data into our Panorama tracking system, which BC can access for their residents.

Regarding data sharing, our focus has been with Yukon First Nation governments given geographic case rules for reportable diseases. We are open to sharing data with transboundary First Nations; however, transboundary data is challenging, as the Yukon will only have data on non-Yukon residents if they receive services in the Yukon. Often, this data will be incomplete and potentially of the limited use.

For the third question, as previously mentioned, we have one data-sharing agreement established with the Kwanlin Dün First Nation, which has recently been expanded and updated. We remain committed to working with First Nation partners within our current legal framework, recognizing data sovereignty as a critical and important issue for First Nation governments.

Chair: Mr. Kent, we have time for one more question before our break.

Mr. Kent: Mr. Chair, my final question of the day is, again: Have all Yukon and affected transboundary First Nation governments been asked about their willingness or interest in establishing these protocols that were referenced by the Auditor General?

Ms. Boyd: We have not formally approached every First Nation individually about their willingness or interest in establishing data-sharing agreements. That said, we have raised the option at many joint meetings and are available to discuss it with individual First Nation government representatives on an ad hoc basis or as the opportunity arises.

As mentioned above, we are in discussion with the Council of Yukon First Nations data-governance team about presenting to the Health and Social Development Commission on data-sharing protocols and agreements.

Chair: My clock shows 2:58, so we will just round up to 3:00 and break. We will be returning at 3:30 as per the direction you had received previously. We will proceed at that time with the rest of the predetermined questions as well as any follow-up questions that the Committee may have.

We will break now until 3:30.

Recess

Chair: We will get back to action here. We will pick up where we left off.

Hon. Mr. Mostyn: Mr. Chair, here we are — the closer. We have nine questions left. We are in a rapid-fire round. We are going to be talking about the monitoring of and reporting on the vaccine rollout, which had some weaknesses based more specifically on the section on inefficient manual systems to monitor inventory and waste. Paragraph 75 makes the following recommendation: "The Department of Health and Social Services should develop accurate and comprehensive inventory systems and practices to track vaccine inventory wastage and expected coverage. The information should be used for decisions on timing and quantities of vaccine needed and to track the movement of vaccines in real time across the territory."

The question I have is for the Office of the Auditor General. The departments have indicated that they are implementing a new system in response to this recommendation. Is the Office of the Auditor General aware of this system being used in other jurisdictions, and can you provide any comment about the efficacy of the system?

Mr. Hayes: We are not aware of this particular system being used in other jurisdictions. It is possible, but we are not aware of it. As mentioned earlier, though, we do know that audits across the country have signalled the importance of being able to monitor inventory and track vaccine wastage accurately, so I wouldn't be surprised if similar systems or even this one are used.

Hon. Mr. Mostyn: Mr. Chair, thank you for that answer. For the officials: Has this been started, and are there established solutions to managing medical inventory or other jurisdictions that you have explored options with?

Ms. Boyd: The Department of Health and Social Services recently implemented a new electronic vaccine inventory management system integrated with the existing Panorama vaccine registry. This system provides real-time inventory data across all facilities that store publicly funded vaccine products. Accurate inventory levels will allow the department to better estimate vaccine product needs over time and inform our ordering pattern and ultimately reduce wastage.

Hon. Mr. Mostyn: Mr. Chair, I have a follow-up for the officials. What steps have been taken so far with regard to implementation of the new system?

Ms. Boyd: We are happy to report that the new vaccine inventory management system is up and running and fully functional.

Hon. Mr. Mostyn: Thank you very much, Mr. Chair. For the officials: Will this system include independent pharmacies or other organizations that administer vaccines?

Ms. Boyd: The system includes all sites that store publicly funded vaccines, including our community health centres, hospitals, as well as local pharmacies.

Hon. Mr. Mostyn: For the officials: Is the system referenced specific for vaccine inventory management, or is it more general?

Ms. Boyd: The vaccine inventory management module is specific to vaccines and is part of the Panorama vaccine registry suite of integrated systems developed and maintained by BC's Provincial Health Services Authority.

Hon. Mr. Mostyn: Is the system referenced currently used in other jurisdictions, particularly other jurisdictions that use the Panorama system?

Ms. Boyd: Yes, it is currently used in BC and in a number of other provinces in Canada.

Hon. Mr. Mostyn: How much did the new system cost?

Ms. Boyd: The Yukon was already fully integrated into BC's PHSA Panorama suite of integrated solutions, so no new system was required, but the cost of configuring and implementing the module in the Yukon was $114,000, and this work was performed by the Provincial Health Services Authority of British Columbia.

Hon. Mr. Mostyn: A question near and dear to my heart: When was it procured, and what was the procurement process used to acquire the new system?

Ms. Boyd: This was a sole-source contract directly awarded to the Provincial Health Services Authority of BC, as there is no other provider that could configure this system, as it was owned and operated within the PHSA.

Chair: That concludes the pre-determined questions that the Committee had collectively devised previously and have been shared with witnesses. I will now open it up for follow-up questions from the Committee. I will start with Minister McLean — I believe you have one.

Hon. Ms. McLean: I have a couple of questions, the first one for the Auditor General's office. I note that in your opening statements and throughout the testimony today, you talked about ineffective collaboration and communication with Yukon First Nations and that it was a missed opportunity to work and understand Yukon First Nations' needs throughout the pandemic.

I wanted to know — and you also had talked a little bit about other jurisdictions and audits that have happened in other jurisdictions. How did other jurisdictions collaborate and engage with provincial and territorial Indigenous populations?

Mr. Hayes: The other audit that we did of a territory was in Nunavut. I will acknowledge right off the bat that the logistics and realities of Yukon and Nunavut are very different, but in the case of the Nunavut audit that we did, we did see that there was collaboration with the various communities. There are a tremendous number of fly-in-only communities there, so the logistics might have been different, but I think that it is still an important factor to consider. There are individual realities in each of these communities. There are obviously different interests at play, so I would say that, in the Nunavut case, we did see some good collaboration.

I think that I would use this opportunity to say that the recommendations that we made are really geared toward helping to make sure that there can be early, often, and meaningful collaboration. We picked those words intentionally, because "early" means that you can hear about the interests of the communities as you are designing, "often" means that you can vector check, and "meaningful" means that the interests are being listened to.

I would acknowledge all the way through that the efforts of the departments in this crisis were tremendous. This is an area that I think overarches everything across the government. This is the time to build trust.

Hon. Ms. McLean: I note that one of the questions today was directed to the Auditor General, and I have just asked a follow-up question around this. I wanted to give an opportunity again — in quoting paragraph 54, found that Yukon First Nations were not involved in pandemic and emergency planning, nor were they given the opportunity to provide input on the Yukon's COVID-19 vaccine strategy, which was made public on December 10, 2020.

The auditors also found that First Nations were briefed late in the planning of the vaccination rollout and had limited input throughout the implementation. Again, this is found on page 18, paragraph 54. There is other context within that section, but I wanted to give the department officials an opportunity to respond to that.

Mr. MacDonald: Thank you for the opportunity to follow up on that question.

During the pandemic, as we have indicated, a number of committees stood up to help with engagement. I think, as we have indicated, there were a number of committees that we had established at all levels of government, from the leadership right through to officials in First Nations, during the pandemic. We did find that there were some challenges in communication, recognizing that comment.

Many of the First Nations actually chose to close their offices, so we were able to utilize, I think, through Aboriginal Relations and Community Services, a lot of our own contacts that we had engaged with communities — both municipal and First Nation — to help continue conversations and contact, but we didn't have the normal day-to-day business in many of those situations.

We did continue to utilize a lot of the formalized processes that we do have — not necessarily for engagement but for intergovernmental relationships — to continue those processes. We do recognize that the processes we do have established are not intended to be engagement mechanisms but rather to continue to promote government-to-government relationships among all levels of government. We have a senior officials group that continues to work together collaboratively to help set priorities between the governments. The senior officials group is comprised of the senior officials from my office at the director level, along with the executive directors from each of the Yukon First Nations. They have an opportunity to participate and help set the priorities and the agendas for each of the forums and interactions we have both within the Yukon Forum agenda setting and the intergovernmental forum — we just recently completed one in Ottawa — and also the joint senior executive committee, which is a collection of all the deputy ministers and the executive directors of each of the self-governing First Nations, have an opportunity to get together.

In all of these situations, it is a collaborative process of agenda-setting where we agree to the agenda and the topics that would be discussed at those meetings. Sometimes, COVID-related matters were on them; other times, there were other priorities that took precedence for those conversations, but in every one of those opportunities, we were able to engage either at a chiefs level or at a ministerial level — bring Cabinet together — to have these conversations. There were conversations that did include pandemic-related discussions, but in those cases, it was dependent upon what issues that the chiefs and the ministers chose to speak about.

I think, as well, we did establish intergovernmental accords, which we have with many of the First Nations and which helped to set the priorities that each one of those governments would like to focus on. In some cases, it is health-related; in other cases, they have other things — be it infrastructure or otherwise — but very much taking the lead from First Nations on how they would like to prioritize the issues of importance to those First Nations.

As well, I would just mention that we do recognize that there is a need for a more fulsome conversation on emergency measures and how to react to some of those things. At the

intergovernmental forum that we had in Ottawa, First Nations did put forward a discussion on emergency measures, and we were able to have a trilateral conversation among ministers, chiefs, and our Cabinet on those issues as well.

I think in all of those situations, we have been able to try to work collaboratively on these. Obviously, in some situations, as I have said, with First Nations being closed, sometimes the capacity to be able to have a more fulsome engagement was not always there. Unfortunately, sometimes the timing probably made it challenging to be able to do some of those interactions more fulsomely, but I think the opportunity that we did do — the officials did a great job of trying to make themselves available and be proactive in those relationships to be those points of contact for First Nations. In some of the things, like the CYFN report that was done around the COVID response, they did highlight those proactive relationships as being a key part to the communication.

Mr. King: I would just like to put some highlights on some of the outreach and the engagement work that did happen during the vaccine rollout. I can speak just briefly to some of the work that we are doing now and in the days ahead.

I have already mentioned this, but I would just like to emphasize that the COVID-19 community leadership call meetings, which happened on a daily basis at times and then moved to weekly — we had feedback that it was a very effective forum to connect the chief medical officer of health directly with leaders in communities.

The format of the call even changed throughout the pandemic where our technology at the start was conference calls and, by the end of it, we were on Zoom or Teams meetings. Those meetings happened on a regular basis, and we heard it was an effective way to share information with leadership in communities, take feedback, and certainly try to ensure that our plans were integrated.

The other things I would mention is the Aboriginal Relations community outreach team, the Yukon First Nation COVID response communication calls, First Nation leadership meetings, community liaisons as well — I would just like to emphasize the role that the community liaisons played. These were individuals with the Community Affairs branch and also with Aboriginal Relations, and the intention of that role was to try to ensure that we were coordinated with First Nation governments and local officials as we came into communities.

There were some 80 people brought in across government into the emergency coordination centre to support the vaccine rollout. They were organized into different teams — teams Togo and Balto, they were called at the time. We had a tremendous effort by public servants from across government to organize the clinics to ensure that we were able to adjust on the ground. Through that, it meant trying to connect with the right people who had the local knowledge and ways of doing so that we could make adjustments and be respectful and effective, I suppose, for the needs of that particular community. There were different levels of success, but I think that overall that collective effort had a lot of energy and a lot of buy-in from across the territory. Those processes were part of, I think, the success that we saw with the implementation of the vaccine mandate and the rollout.

I think we can always do more. The relationships and the need for coordination on our emergency plans with First Nation governments and municipalities is key — both being deliberate on the structures but also intentional on the communication and the planning around communications. As I just mentioned, it's making sure that we are incorporating local knowledge and ways of doing things so that our plans are truly collaborative when we're in communities and to ensure that we have really clear responsibilities and understanding of overlapping jurisdiction, which can be a challenge.

So, that is some of the work that is happening now with the Emergency Measures Organization and through the conversations that are happening about emergency plans.

Ms. Boyd: Thank you. I will be fairly brief, but I do want to highlight some of the work that is happening in Health and Social Services with respect to how we are evolving our approach to — as Mr. Hayes put it very well — early, often, and meaningful engagement with Yukon First Nations, which is very, very critical. You know, we take to heart the responsibility to take the findings and learnings from the audit and the feedback we have received and incorporate those into how we go forward and do things differently and better. Improving health outcomes for our First Nation citizens is critical, and evolving our health system to address cultural safety, to support meaningful engagement, and to start to evolve to consider things like the Indigenous determinants of health is absolutely critical.

To that end, we have evolved our governance model in health to one that I think is frankly leading in the country around how we do this work differently and together for the betterment of all. We have built a governance structure that includes a Chiefs Committee on Health that was established through the First Nation leadership, which oversees, in parallel with a subcommittee of Cabinet — what we refer to as HTAC, which is the health transition advisory committee. Its membership includes three First Nation members, the two deputies of Health and Social Services, and the CEO of the hospital — folks responsible for operationalizing health care in the Yukon — health and social supports.

Together, our mandate is to implement *Putting People First*. Collaboratively, we have a consensus-based model to support decision-making as we move forward, and we take that work very seriously. We have been meeting regularly, sometimes on a cadence of weekly. I share the responsibility of co-chair with Stephen Mills, and he and I meet between meetings. We have found this to be incredibly helpful. We need to take the lead from our partners on things like cultural safety, and we greatly appreciate the opportunity to work with our partners to do that differently and better. It is for work like on vaccine rollout, but it is not limited to that; it is the entire health and social system.

I am very proud to highlight that we deeply appreciate the feedback that we have received, and we are doing our best and will continue to do our best and do better as we know better to make those necessary changes in the health system.

Mr. Kent: I just have one question, and you may or may not have the answer today, but if you could follow up with a letter, that would great, and that is just with respect to adverse reactions. We have heard anecdotally about some adverse reactions that people have had to the vaccine. I have seen some of the national numbers. They are very low, but I am just curious how the Yukon numbers compare and if you have tracked the severity and number of any adverse reactions to either of the two mRNA vaccines — the Moderna or the Pfizer — or the non-mRNA — I think that it was Johnson & Johnson that we used. If you don't have those, I would just appreciate a letter back to the Committee; that would be great.

Ms. Boyd: Yes, we can provide that back in writing.

Ms. White: This is specifically around the Emergency Measures Organization. Some of the things that were heard kind of early on in the pandemic and as things rolled forward is that it was a small team who had to bring people in from outside. Some of the concern is, going forward, instead of looking at bringing people in when things are happening — kind of in a crisis mode — as to whether or not building up that team makes sense. If we can have the witnesses expand on the current makeup of what that team looks like, what is expected — for example, what was the build-up during the pandemic? What was the build-up during the wildfires, because although they are different emergency events, they are emergency events that team, I imagine, leads.

Mr. King: Thank you for the question. Yes, you are right in that the Emergency Measures Organization itself is a fairly lean organization. I am not sure how many positions exist within the branch — probably six to seven, I would guess. That team is certainly too small to take the lead on coordinating a response. That is why we use the emergency coordination centre, which is sort of an extension of the Emergency Measures Organization. It is physically co-located, but each of the positions within the emergency coordination centre are defined within an incident management structure, and we have individuals across government — across all departments — who are trained to fulfill any and all of the functions and the roles within the emergency coordination centre under that incident command structure.

So, we have really made efforts to ensure that there is training and there is available rostering of people for the key roles that are required in the emergency coordination centre — certainly during response seasons, as we see with fires or floods, but more generally for other emergencies that could present themselves, such as a pandemic.

One example is that we have a 24/7 roster for the information officer role within the Incident Command structure. Those are individuals who sit across government, and they take various shifts just in case there is a requirement to call them into the emergency coordination centre or support something that happens after hours.

Fatigue is a real concern, and certainly the pandemic, I think, highlighted that and brought a strain on staff and the public service — well, everybody, but including those front-line workers who were in the emergency coordination centre. The strategy that we have is to just make sure that we have a larger roster, that there is lots of training available, and that training is available on a regular basis not only for Government of Yukon employees but also ensuring that training is available to partner organizations or partner governments that are also likely to be in the midst of response.

I can leave it there.

Ms. White: I appreciate that, and I am on my phone, so I did not download the 103-page document, but it says that the *Yukon Government Emergency Coordination Plan* was last updated on December 14, 2018. The plan was originally — according to this — published on May 1, 2007. So, understanding that, since 2018, we have had a significant event occur — and I was going through my notes trying to figure out what plans you had listed before that were being updated, but are there plans to update the *Yukon Government Emergency Coordination Plan*?

Mr. King: Yes, the *Yukon Government Emergency Coordination Plan* is currently under review and is being updated on the timeline of 2024, when we expect to have that plan updated. Currently, we are reviewing what is written in the plan against what we have learned through recent events — including the pandemic, including wildfires — to ensure that we are capturing the most efficient best practices and ensuring that our plans reflect best practice. That work is underway right now.

Chair: Before I adjourn this hearing, I would like to make a few remarks on behalf of the Standing Committee on Public Accounts. First of all, I would like to thank all the witnesses who appeared from all the departments. I would also like to thank the Office of the Auditor General of Canada for their work on the audit report.

Transcripts of this hearing and documents provided by the departments will be available for the public to consult on our webpage, yukonassembly.ca/committees/pac.

Today's hearing does not necessarily signal the end of the Committee's consideration of the government's emergency response programs and the delivery of vaccines in Yukon. The Committee may follow up with the departments on the implementation of the commitments made in response to the recommendations of the Auditor General and of the Committee itself. This could include a follow-up public hearing at some point in the future and further Committee reports.

With that, I would again thank all those who participated in and helped organize this hearing. I now declare this hearing adjourned.

The Committee adjourned at 3:58 p.m.