**Second Session – Forty-Third Legislature**

**of the**

# Legislative Assembly of Manitoba

# Standing Committee on Public Accounts

***Chairperson***
***Mr. Josh Guenter***
***Constituency of Borderland***

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**Forty-Third Legislature**

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**LEGISLATIVE ASSEMBLY OF MANITOBA**

**THE STANDING COMMITTEE ON PUBLIC ACCOUNTS**

**Monday, May 26, 2025**

***TIME – 6:30 p.m.***

***LOCATION – Winnipeg, Manitoba***

***CHAIRPERSON – Mr. Josh Guenter (Borderland)***

***VICE-CHAIRPERSON – MLA Jim Maloway (Elmwood)***

***ATTENDANCE – 7 QUORUM – 6***

*Members of the committee present:*

*Mr. Brar, MLA Compton, Messrs. Ewasko, Guenter, MLA Maloway, Mr. Oxenham, Mrs. Stone*

***APPEARING:***

*Tyson Shtykalo, Auditor General of Manitoba*

***WITNESSES:***

*Charlene Paquin, Deputy Minister of Housing, Addictions and Homelessness*

*Chris Christodoulou, Interim President and Chief Executive Officer, Shared Health*

*Jitender Sareen, Shared Health Provincial Specialty Lead, Mental Health and Addictions*

***MATTERS UNDER CONSIDERATION:***

*Auditor General's Report – Addictions Treatment Services in Manitoba, dated July 2023*

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**The Chairperson:** Good evening. Will the Standing Committee on Public Accounts please come to order.

This committee has been called to consider the following report: The Auditor General's Report– Addictions Treatment Services in Manitoba, dated July 2023.

Are there any suggestions from the committee as to how long we should sit this evening?

**MLA Jim Maloway (Elmwood):** Mr. Chair, we'd recommend that we sit for one hour 15 minutes and then revisit at that time.

**The Chairperson:** It has been suggested that we sit for one hour and 15 minutes and revisit at that time, if necessary.

Is that agreed? *[Agreed]*

At this time, I will also ask the committee if there is leave for all witnesses in attendance to speak and answer questions on the record, if desired.

Is that agreed? *[Agreed]*

Leave has been granted.

I would also like to remind everyone that questions and comments must be put through the Chair using third person, as opposed to directly to members and witnesses.

Before we proceed further, I'd like to inform all in attendance of the process that is undertaken with regard to outstanding questions. At the end of every meeting, the research clerk reviews the Hansard for any outstanding questions that the witness commits to provide an answer to and will draft a questions-pending-response document to send to the deputy minister. Upon receipt of the answers to those questions, the research clerk then forwards the responses to every Public Accounts Committee member and to every other member recorded as attending that meeting.

Does the Auditor General wish to make an opening statement?

**Mr. Tyson Shtykalo (Auditor General):** First, I'd like to introduce the staff members I have with me tonight. Tonight I'm joined by Jon Stoesz, audit principal, and Zsanett Magyar, auditor, both of whom worked on the report Addictions Treatment Services in Manitoba.

Mr. Chair, substance use and addictions can have a devastating impact on individuals, as well as those around them. Manitobans experiencing addictions issues are more likely than the general population to be accused of, or become the victim of, a crime. They are also more likely to visit an emergency department and much more likely to die before age 75.

Effects on family members and others close to a person experiencing substance use and addictions may include emotional and economic barrier–burdens, relationship distress and family instability.

In this audit, we looked at whether Manitobans had access to appropriate addiction treatment services when they needed them.

Mr. Chair, we found appropriate addiction treatment services were often not available to Manitobans when they needed them. More specifically, we found that capacity did not meet the demand for addiction treatment. As a result, people continue to experience long waits.

These issues are amplified in rural and–rural areas and in the North, where some treatment options were severely limited. For example, only 14 per cent of detox beds were located outside of Winnipeg.

In addition, a fulsome system-wide picture of addiction treatment services in Manitoba did not exist. This is because the delivery of addiction treatment is decentralized, records are still largely paper-based and data collection is siloed.

This is further challenged by poor data quality. As a result, it's extremely difficult to track a person through the addiction treatment–sorry, track a person through the addiction treatment system.

We also found there was a lack of co-ordination across the different types of treatment services. Different service providers, both in the public system as well as not-for-profits and private providers, need to work together and co-ordinate to provide treatment and care to individuals with addictions, regardless of how a health-care system is structured.

This report includes 15 recommendations to improve the delivery of addiction treatment services in Manitoba. I encourage the Department of Housing, Addictions and Homelessness and Shared Health to work with all service delivery organizations to act on these recommendations to resolve the risks identified by this audit.

I'd like to thank the many provincial government officials and staff, and the many other stakeholders we met with during our audit. Their co-operation and assistance is much appreciated.

I would also like to thank my audit team for their due diligence and hard work completing this report.

I look forward to the discussion today on this report.

**The Chairperson:** I thank the Auditor General for his opening comments.

Does the deputy minister of Housing, Addictions and Homelessness wish to make an opening statement, and would she please introduce her staff joining us here today?

Thank you.

**Ms. Charlene Paquin (Deputy Minister of Housing, Addictions and Homelessness):** Good evening and thank you for the invitation to provide some opening comments and speak to the Department of Housing, Addictions and Homelessness's response to the Auditor General's report on addictions treatment services in Manitoba from July 2023.

With me from the department, I have Nolan Aminot, who's our acting director of the Mental Health Addictions Treatment and Recovery Branch, and Ann Marie Hayek, who's the senior policy analyst with the Mental Health Addictions Treatment and Recovery Branch as well. So want to thank them for all the work that they've been doing behind the scenes moving this forward as well.

Ensuring individuals have access to appropriate addictions support and treatment services when they need them is a priority. It's a priority for the department, and we know it's been a priority for the government for a long time.

I'd like to acknowledge the work of the Auditor General and the–and his office on this audit. The audit provided an opportunity to examine some of the addictions services available in Manitoba. And it's provided and helped to strengthen the addictions treatment system to ensure Manitobans have access to the services they need when they need them.

I'd also like to acknowledge our colleagues here from the department–my colleagues from the department, from Shared Health, who are also joining us here today: Dr. Christodoulou, Dr. Sareen and Ben Fry. Shared Health is an essential pillar in the health-care system, and they bring expertise, co-ordination and leadership to mental health and addictions service delivery across the province.

As the provincial health authority in Manitoba, Shared Health has been a key partner in responding to the recommendations of this audit report. This partnership has been integral to supporting improvements in addictions services in our province, and by working together we create a system that evolves and expands to meet the growing and changing needs of Manitobans. We will continue to work with Shared Health to address the recommendations to help support improvements in addictions 'servances'–in addictions services in the province.

If I can take a moment just to provide committee members and others here with some context on the programs and services discussed in the report. The continuum of addictions treatment services and

supports for adults in Manitoba includes access to addictions medicine through the Rapid Access to Addictions Medicine clinics, or RAAM clinics, as they're–as we'll refer to them; opiate agonist therapy, or OAT therapy; withdrawal management services; a variety of community-based services; day and evening treatment; short- and long-term primary-bed-based addictions treatment; outreach after-care programming; and supportive recovery housing.

Much of this was covered in the auditor's report, but just to briefly recap: withdrawal management services provide support to individuals who want to withdraw from a substance they are using. They are offered, through a few different models, including hospital-bed-based medical withdrawal management services, non-medical-community bed-based withdrawal management services and mobile withdrawal management services that can be accessed in a person's home or other safe place.

RAAM clinics provide walk-in assessment, counselling, prescription of addictions medication, including OAT therapy, as well as referrals to withdrawal management services, community treatment programs and primary-care physicians.

Day and evening treatment programming is available for people who require intensive treatment but wish to return home to sleep. And bed-based intensive primary treatment services are provided through service delivery organizations and several community service providers. These programs provide structured, live-in treatment and last anywhere from 28 days to three months or more.

And then, finally, supportive housing–recovery housing provides longer term accommodation in a stable, supportive, substance-free environment to individuals who have completed addictions treatment.

Publicly funded substance use and addictions services and supports in Manitoba are provided by Shared Health, regional health authorities, non-profit community organizations that receive government funding, the federal government and First Nations communities. Services may also be provided by primary-care providers such as family physicians or walk-in clinics and private for-profit addictions treatment agencies.

The July 2023 OAG audit of addictions treatment services examined services provided by government service delivery organizations in the Winnipeg Regional Health Authority, Prairie Mountain Health, Northern Health Region and Shared Health.

Just one thing I would note–by no means intended as anything other than additional context–is that because the audit focused on provincial services and did not include the community-based services, private provider services, First Nations or those funded by the federal government, it gives, you know, a good look and indication into what the system is in Manitoba, but not the full picture of all the services available and the impact of those services on capacity to deliver, as well as wait times.

* (18:40)

And so, just flagging that as a contextual piece. And that broader perspective, of course, is important because community agencies play a very big role in delivering Manitoba's publicly funded addiction services.

I think one thing I'd also like to note is just that harm reduction is a key pillar in any comprehensive addiction system. We know that substance use and addiction are multi-faceted and complex and follow a spectrum of service and treatment. Harm-reduction services tend to reduce the health and social harms associated with substance use and play a key role in preventing overdose, limiting disease transmission and keeping Manitobans connected to care, and those services are important to consider in the context of Manitoba's addiction services system as well.

The audit covered the period between July 1, 2017 to June 30, 2022, with a detailed review of the 12 months ending June 30, 2022. In 2023, the department expanded and changed to include the portfolios of Housing and Homelessness. I think this is just important context to have in terms of the work that we're doing today, because addressing homelessness is particularly complex, and the need for accessible and responsive addictions programs and supports has really never been greater.

This requires co-ordinated, multi-faceted responses to address the depths of these social challenges effectively. The mandate of the department continues to support a co-ordinated approach to ensuring the safety and well-being of our province's most vulnerable individuals and that recognizes the connections between addictions and homelessness.

Since the conclusion of the audit report, the government of Manitoba has been responding to the recommendations in the report and has made significant progress in addressing many of the findings. We have a steering committee co-chaired by Housing, Addictions and Homelessness and Shared Health

that's been formed to provide oversight and co-ordinate those efforts and to address the strategic initiatives.

Housing, Addictions and Homelessness has been working with Shared Health and service delivery organizations to track the progress on each of the 15 recommendations, and I'm pleased to report that together we've partially or fully addressed 14 of the 15 audit recommendations since '22-23 through structural changes and capacity increases.

Some examples of initiatives that are complete or are in process that support several of the audit recommendations include drafting of the substance use and addiction standards for adoption by publicly funded base–bed-based addiction services, implementation of the accountability and performance management framework, the Access, Intake, Assessment and Coordination project, and needs-based planning.

The one recommendation that requires, I think, some further work and additional focus is recommendation No. 4, that we adopt an electronic records management system for addictions treatment services and ensure that all addictions-treatment providers are using the same system. This work is ongoing, and we continue to work with Shared Health in that regard. We certainly agree with the recommendation and see it as a priority.

In addition to the progress that we've made with the audit recommendations, the government of Manitoba has made significant investments to increase access to services and supports, including expanding the capacity of RAAM clinics, various levels of withdrawal management services, opioid–opiate agonist therapy, short- and long-term addiction treatment, supportive recovery housing and outreach, and intensive day programs. We're also working with our partners to bolster our harm-reduction response to reduce overdoses, and this includes distribution and disposal of harm-reduction supplies and also includes drug-checking services that reduce the harms associated with the toxic drug supply. We also work closely with Public Health to ensure Manitobans have access to naloxone in the event of drug toxicity or overdose through Manitoba's Take Home Naloxone Program.

Again, we're committed to improving the addictions treatment services system for Manitobans, and I again want to thank the Auditor General for this important report and believe we've made significant progress on 14 of the 15 recommendations and pleased to have the opportunity to answer any questions from the committee.

**The Chairperson:** I thank the deputy minister for those opening comments.

Does the interim president and chief executive officer of Shared Health wish to make an opening statement, and would he please introduce his staff joining him here today?

**Mr. Chris Christodoulou (Interim President and Chief Executive Officer, Shared Health):** Good evening, and thank you, Mr. Chair, for the opportunity to present and answer questions related to Shared Health's work in response to the Auditor General's Report–Addictions Treatment Services in Manitoba, dated July 2023.

My name is Dr. Chris Christodoulou. I'm the interim president and CEO of Shared Health, and I'm joined this evening on my right: Dr. Jitender Sareen, right behind me here, the provincial psychiatry specialty lead for Shared Health, and also the head of the university department of psychiatry at the University of Manitoba. Ben Fry, to my left, is the chief operating officer for Mental Health and Addictions within Shared Health. And I'm pleased to have this opportunity to update the Standing Committee on Public Accounts as it relates to the office of Auditor General report on addiction treatment services in Manitoba.

I'd like to thank the committee for the opportunity to provide comments and respond to questions and offer our gratitude to Auditor General Tyson Shtykalo and the office of audit professionals. I want to acknowledge their professional and collaborative relationship with Shared Health and our staff.

These reviews are both rigorous and complex and are welcomed by Shared Health to not only highlight what is going well but more importantly, to identify areas for improvement. The issue of addiction remains a significant one in Manitoba. Over the past few years, we have seen a significant increase in the demand for addictions services throughout our province. In addition, the complexity of challenges faced by those seeking care has risen substantially as we see an influx of more potent and often toxic substances into Manitoba.

In the past few years, the mental health and addictions system has undergone significant reorganization with a primary goal of meeting this increased demand and improving services for patients and families. This includes provides timely access to services through evidence-based assessments and matching Manitobans to the services that address their

addiction and substance use needs. This can be a combination of 24-7 services such as in-house treatment facilities or outpatient services like medical clinics that focus on withdrawal options and counselling, such as those provided in Rapid Access to Addictions Medicine clinics across Manitoba.

The Office of the Auditor General report contain 15 recommendations; some of those were directed to the Department of Housing, Addictions and Homelessness department, while others were focused upon Shared Health and our Shared Health and regional health authorities. There are several of these recommendations with shared responsibility between both the department and Shared Health.

We are pleased to share that, of the recommendations directed to Shared Health, one has been fully addressed while significant progress has been made on the remaining items. The recommendation that is fully addressed: recommendation No. 3, Shared Health co-ordinate learning and conferencing opportunities for all service delivery organizations' employees providing addictions treatment as well as government-funded non-profit service providers. The recommendations still in progress–and I will just list the numbers here for the committee–are items 2, 9, 10, 11 and 14.

The aforementioned recommendations–there were multiple themes throughout the OAG report, many of them centred on reducing barriers for Manitobans to access the necessary supports and care that they need. The importance of collaboration across the service system and embracing interventions that work was also stressed in the report. This includes strengthening the role of the RAAM clinics, access to medical withdrawal services and ensuring that we are recruiting and retaining professionals who specialize in addictions medicine.

I wanted to highlight virtual options for a moment. The Rapid Access to Addictions Medicine Digital Front Door program enables clients to access these services by using either their laptop, a tablet or a phone. The experience is similar to using WhatsApp, FaceTime or Instagram accounts. Recent expansions of cognitive behavioural therapy also help Manitobans to access free therapy and coping strategies virtually. By providing these options, we are reducing barriers to care that people may experience in accessing those mental health and addictions services they require.

There are mobile withdrawal management services in operation within Prairie Mountain Health and Southern Health-Santé Sud, while Klinic Community Health operates a mobile service within Winnipeg. The Aboriginal Health and Wellness Centre RAAM clinic launched a mobile clinic in July of 2024.

The planned access intake assessment service for mental health and addictions will also move to a more streamlined one-stop shop for Manitobans seeking services and will improve wait-list management and improve matching of clients to services that are required.

The co-ordination of learning and conferencing options was also highlighted in the report. One such example is Project ECHO, which stands for extension for community health outcomes. The project functions to connect providers from across the province to increase collaboration, strengthen addictions medicine competencies and thereby improve service delivery to our clients.

* (18:50)

Looking more broadly, there are important efforts under way to also improve the experience for adults accessing the addiction services systems. This includes ongoing investments from the Manitoba government, and Housing, Addictions and Homelessness in particular.

In 2024, a review and redesign of the community mental health and addictions services, with a particular focus on clinical and treatment services delivered in the community and outpatient settings, was commissioned. The committee tasked with this work is in the process of completing a report that will identify potential opportunities to further enhance community-based care.

Additionally, work to develop a mental health, substance use and addictions systems strategy for Manitoba youth will commence in the coming weeks with similar goals.

Thank you for your attention tonight. Your interest in this important public health issue and your ongoing approvals for funding from government to current and expansion of services for all Manitobans is greatly appreciated and welcomed.

Thank you.

**The Chairperson:** I thank the CEO for his opening comments.

The floor is now open for questions.

**Mr. Wayne Ewasko (Lac du Bonnet):** I'd like to thank the department and, of course, Shared Health for attending today, as well, and thanks to the Auditor General for bringing forward your report.

So I'd like to ask, through you, Mr. Chair, can the department expand on some of the RAAM clinics' information, if they can touch on where the current RAAM clinics are, when did they open and what's some plans for future locations?

**Ms. Paquin:** I thank the member for the question.

There are currently seven RAAM clinics in Manitoba: three in Winnipeg and one each in Selkirk, Brandon, Thompson and Portage la Prairie.

Virtual services have also been launched using nurse-led digital front-door clinics to expand accessibility more widely across the province.

Hours of operation vary somewhat by location, with most clinics open five days per week and physicians available for defined clinic times.

Saturday services are also offered by two Winnipeg clinics: Crisis Response Centre and Aboriginal Health and Wellness Centre.

And I appreciate the member asked a question about the opening of the RAAM clinics. I don't have those dates with me. If we can undertake to get that information back, happy to do so.

**Mr. Ewasko:** Just a quick follow-up. Thanks to the deputy minister for the answer. And then thank you, also, for the upcoming information that'll be brought forward in the future.

Is there–according to the Auditor General's report, is there plans for future ones that you can talk about?

**Ms. Paquin:** Again, thanks to the member for the follow-up question. And I just–I want to say I appreciate the caveat of, you know, what you can share and understanding that.

I don't have anything specific that I can commit to as far as future expansions at this point. But what I would like to add is that ensuring individuals have access to appropriate addiction support and treatment when they need them is a priority, and I think that we've seen real success with the RAAM clinic model and continue to see increasing numbers of people accessing those supports.

The continued investment in RAAM clinics and the addition of virtual services through the digital front door that Dr. Sareen–or sorry–Dr. Christodoulou had mentioned, and the northern referral pathway is providing more access to RAAM clinics through different means than walk-in only. And so I just wanted to reiterate that, as well as the education initiatives that are ongoing to increase addiction medicine capacity within primary care, including the RAAM Knowledge Exchange and the ECHO Program that, again, Dr. Christodoulou had mentioned in his opening comments as well.

**MLA Carla Compton (Tuxedo):** One of my always first questions is around data, and that was one thing the Auditor General really lifted up, and, you know, the nurse in me, I can't help but ask for the evidence and data and stuff, and I know that was a serious critique of lack of data, poor data, tracking, all that kind of stuff.

So I'm curious what has been in–has been put in place or is being put in place for better data collection of what is, as well as informing, you know, our actions, getting the results that we want or do we need to tweak–by that.

**Ms. Paquin:** Thank you to the member for her question.

Data is currently being collected through the Shared Health data exchange portal, which enables standardized data submission across all the service delivery organizations and community agencies. There are 10 key performance indicators that are currently being collected, including wait times, service utilization rates and occupancy metrics.

***** (19:00)

The portal collects data on four indictors while the remaining six indicators are reported through the provincial information management and analytics unit. The APMF management framework is already implemented with baseline data collection and analysis under way. Complete refinement of the framework is anticipated by the second quarter of this year, and the framework's already operational and providing valuable system performance insights internally, even as the department continues to refine and enhance its capabilities.

And I would echo the importance and support for good data in this work and for good data to drive evidence-based decision making when we look at increasing treatment services and recovery services for individuals. So that's something that I think our shared areas have been working very hard on and will continue to refine and strengthen as time goes on.

**Mr. Diljeet Brar (Burrows):** My question was stolen, actually. I had the same question. So, thank you, that saves time.

I would ask a general question. Before that, I want to say thank you to the AG office. Thank you to the department for what you're doing for Manitoba. And I also want to welcome friends from Shared Health.

I have a general question. The report talks about barriers to treatment services, talks about few services in rural and northern areas, lack of capacity and co-ordination for opioid agonist treatment.

So I want to ask, simply, between when the report was done and now, what kind of improvements–maybe infrastructure improvements or staffing improvements–were some barriers that we were able to remove? So what's the update on that?

**Ms. Paquin:** Again, thank the member for the question. Certainly, barriers to access are well acknowledged, and some of the significant ones, I think, that we've seen through the department relate to geography: rural, northern and remote communities in particular in Manitoba, as is often the case with service.

And so we are working to increase capacity for addiction services and supports in each of the five health regions to enable Manitobans to access services close to their home communities. We have RAAM clinics in every region now; we have mobile withdrawal management services as well as medical withdrawal management services in every region. So that's, I think, significant.

The awareness of services is also tends to be a barrier to access, and that's being addressed through updated Shared Health and regional health authority websites, Manitoba Addictions Helpline, Manitoba 211, along with the work we're doing around access intake and assessment and co-ordination.

The other piece is stigma, and this is–oh, yes. So this is also being addressed through the development of standards and training for service providers. I think that's a really important thing. We're still seeing a lot of that in community, let alone with providers, and it's being addressed through the provision of harm reduction supplies and services in communities and in partnership with the service delivery organizations.

And one other noteworthy piece I would say is we also now have 320 opiate agonist therapy providers that are trained in the province as well to prescribe OAT.

And so those are some examples of things that have increased in the last period.

**Mr. Brar:** Thanks for that information.

When we talk about awareness and stigma, it reminds me about ethnic communities and new Canadian families. There is way more stigma in some particular communities, I would say. Is the department considering using some ethnic media or other tools to make those communities aware about mental health issues?

In some cases, people do not even consider that this is mental health.

So is there something on the table to–I mean, information dissemination, creating awareness to those particular groups?

***** (19:10)

**Ms. Paquin:** Thank you again for the question. It's an excellent question.

It's a fantastic point around the–not just the diversity of communities in Manitoba but how those communities experience substance use, addiction, mental health, I think, is really something that we pay close attention to. And we fund a number of organizations to serve different groups, whether they be 2SLGBTQ populations, diverse groups, newcomers, Indigenous communities. And so, you know, again, I thank the member for that question.

There's a few things that–we do fund some organizations and work with a number of newcomer organizations, such as Resilia, previously known as Aurora. Both our department and Shared Health fund Resilia, who provide trauma support, counselling, substance-use support and other mental health services specifically to newcomer groups. And so that's one example of where we are providing that support.

I think it's also worth noting that the Access, Intake, Assessment and Coordination initiative–in the future, the portal will allow for people to identify, you know, what groups they come from if–should they so choose. So we'll be able to collect more demographic information than we do now, and I think that gives us real opportunity in the future to then, again, use that data to better target outreach to specific community groups.

So there is some work being done now, and we do fund some, but I think your point is a really good one around making sure that we stay in touch with all of the diverse groups that we work with, making sure they get the information that they need.

**Mr. Brar:** Not a question, just a comment. In my experience interacting with such organizations, recently I got a chance to attend a few events organized by Healthy Muslim Families and Punjabi Community Health Services, just to note two of them. So they're doing great, so could be considered.

Thank you.

**MLA Compton:** I have a question around the one recommendation that's still in action but is ongoing: the adoption of electronic health records.

I'm curious if they're thinking around is it– is what's happening, what type of record; is it going to be something that's integrated throughout not just the mental health-addictions component, is it something that's going to connect in with the whole system. I say this as someone that comes from a program that literally I would be documenting between two different electronic records and paper stuff for one patient.

So I'm just very curious around what the plan is or is looking like for the electronic record component.

**Mr. Christodoulou:** I'd like to thank the member for this excellent question.

The digital health unit within Shared Health Services is on a road map to achieve implementation of a digital electronic clinical record for the 63 acute-care facilities in Manitoba, and that road map is on track for September of 2027 to have the project completed.

Now, there are multiple projects within this big project, and that includes updating all the emergency department information systems across all of these acute-care hospitals. There's the building of the clinical documentation component of the electronic clinical record so that whether you're in Flin Flon, Manitoba or Winnipeg at the Health Sciences Centre that providers can see your information across facilities.

The third portion is what is known as the clinical formulary, so when an order is placed and entered into the system, that our pharmacy colleagues can access that and dispense that medication on the wards to assist the patient with their pharmaceutical needs.

All of this is integrated and all the information captured within this digital electronic clinical record, and we have multiple sites that already have this established, both within Winnipeg as well as in Brandon and Prairie Mountain Health. All of this information is then hosted in the eChart, which is accessible from all primary care offices.

We recognize that there are multiple different electronic solutions that private vendors have undertaken and invested in over the years, but phase 1 of this project is to get all the acute-care hospitals on one single system to address the varied concerns about disparate recording that has implications for patient safety, because whenever there's a handover or wherever a patient needs to be transported from one hospital–let's say you arrive at the Victoria Hospital, you have a cardiac issue, you have to go to St. Boniface Hospital. Handovers of care are points of vulnerability, and this one solution will address that. And on a go-forward, the intent would be to start onboarding all the other community providers so that we have information integrated on one single system.

**Mr. Ewasko:** I appreciate the department and Shared Health for the–for their answers.

So, again, sort of going along the lines of what my colleague from Tuxedo has mentioned, when we talk about recommendations four and five in regards to data collection and all of that, we know already that admit–along–whilst the report was getting done by the Auditor General, he did relaunch the Pathway to Mental Health and Community Wellness framework.

Taking a look at the recommendation No. 12, which is the standards, you've already started to create those standards and start implementing them. I guess when we talk about in–and I'm just quoting from your response: In 2023-24, all addictions service providers that receive government funding will be required to meet the standards to receive ongoing funding.

How many total service providers are there, and how often are we going to check with them to do a bit of a shoulder check as far as how are they meeting the–those standards and not necessarily to punish but just how to support and help them in their potential lacking of following those standards?

***** (19:20)

**Ms. Paquin:** Thank you, again, to the member for the question.

I just want to add a little clarification, too, that those standards are applicable to bed-based treatment organizations, withdrawal management treatment and supportive recovery housing providers as well, so not the full continuum of addiction services.

We have about 35 organizations that are expected to adopt the standards, and they are all in process of

doing so. The requirement to adopt the standards are embedded in their funding agreements, and because this is, you know, in process, we are in regular–department's in regular communication and contact with all those providers to support that adoption, answer any questions and continue to support them to fully adopt.

**MLA Maloway:** Electronic health records really caught on in the United States in the '90s, I think probably because doctors get sued there probably way more than they do here. But the Filmon government started a SmartHealth program with IBM in the '90s, and we made fun of it a lot, but it was like $50 million in developing this record, and I don't know how much success they had.

But a few years later, St. Boniface Hospital had a–some sort of an electronic health record. Now you're making reference to–you're developing another program that is going to be fully set up two years from now.

So I'm wondering if you could tie all these things in. Like we–the government went on SAP in '92 or '93, to–so that we did have one standard. And at one time, before Filmon amalgamated all the hospitals into SmartHealth, you had these hospitals basically telling the government what they were going to do. They had their own cooking, they had their own computer systems. They had, like, they had everything, and he had to go and practically threaten them that he wanted take them all–take the boards over if they didn't smarten up and go with the one.

Because whatever system we had, it was always going to be cheaper if we put them all on the same one, okay? So we went with SAP. Now, did the hospitals ever go with SAP? Were they part of that program? So maybe you could kind of update me as to how we got to where we are now.

**Mr. Christodoulou:** Mr. Chair, I'd like to thank the member. It's a wonderful question.

The solution that Manitoba's putting forward that he's building on the 2018 implementation at St. Boniface Hospital, which, as you correctly pointed out, was the first site to launch an electronical record, is with the same vendor. So we will have one, single vendor that is providing the product for all 63 facilities across the emergency department information system, the clinical documentation, as well as the order entry.

Happy to share with the committee that the vendor is Canadian-owned, and that all the information is housed within Canada as it relates to those servers. The scalability and the affordability of the solution has been well researched by our digital health partners at Digital Health, and we're confident that the solution will meet the needs of Manitobans in our acute-care facilities.

There are multiple additional modules that come with this electronical clinical record that include all of the ambulatory clinics. It includes all laboratory and diagnostics: X-rays, CT scans, MRIs, echocardiograms. All information is visible to all the providers that have access across the system.

So we're not looking at disparate systems from multiple different vendors. We've identified one vendor that has a product that meets all of our needs. We know that they have integrity as an organization, and have been a tremendous partner to advance our initiatives. And, yes, it's a tight timeline, but we're confident that our digital services at Shared Health can deliver on this product.

**The Chairperson:** Just a gentle reminder to put questions and comments through the Chair.

**MLA Maloway:** Just a quick follow-up on that. So when you go to the doctor's offices today, you see that they're–they've still got their paper files, but they're more for show now, I think, because they don't ever go look at them. But they've got their little computers in their office.

But they're only able to show you what you're doing with their office. They can't tell you what you did at somebody else's office. So is that all part of the same system here, or is that a different system?

**Mr. Christodoulou:** I'd like to thank the member for that great question.

So private practitioners working in the office clinics, many of them have different electronic clinical records that have to conform to the standards for electronic procurement systems that are set by Digital Health.

Those individual providers are able to access the eChart, so this is the Digital Health-approved eChart. So if you've presented to St. Boniface Hospital–I'll use that as an example–you've gone to the emergency department with chest pain, your laboratory, your investigations, the report that the emergency room physician has entered in, is all accessible from that office.

So they may use a different system to record the visit that you're having with the provider in that particular clinic, but your global information that, once you've accessed an acute-care hospital, is accessible

and available from any point, and all Manitoba providers have access to that.

So there is obviously an array of systems that people implement, just like there are different charting systems that people implement. But this electronic chart that is fed by information that we collate from all our hospital systems is integrated, and it does become a one portal for them to be able to access your information, which is where we need to be for all our patients and families.

**MLA Compton:** One of the things I'm curious about, and my colleague across the way, MLA Brar, talked around stigma in specific communities, ethnic communities and stuff. I'm actually curious around how the work is going with working on the stigma within the medical practitioner community.

Because–when I say medical, not just doctors. Like, how are the changes that have happened in the last–since this report came out, how is it going with maintaining treatment when folks have to access, maybe for non-addiction reasons, the health-care system, how is–is that becoming a barrier to people having their treatment continue?

I just–because someone who–I've known about harm reduction since nursing school in 2000–early 2000s, right? This is not a new concept. It's a strong, evidence-based, proven way of helping people. I've worked with pregnant women on methadone treatment, stuff like that.

But I also know I work with–have worked with many colleagues that have their own concerns and their own misunderstandings, and so I'm curious if that is something that is being worked on as we're updating how we treat folks, how our systems work. Are we identifying where there's barriers within our own system that get in the way of people's treatment that they may already be accessing?

Does that make sense?

***** (19:30)

**Mr. Christodoulou:** Mr. Chair, I thank the member for this great question. I would like to defer the response to this question to the provincial specialty lead for psychiatry for Shared Health and the university head of the department of psychiatry at the University of Manitoba, Dr. Jitender Sareen.

**The Chairperson:** All right, the provincial lead, you have the floor. Go ahead. The provincial specialty lead for psychiatry, you have the floor.

**Mr. Jitender Sareen (Shared Health Provincial Specialty Lead, Mental Health and Addictions):** Thank you for the opportunity to speak and thank you for the excellent question.

And I think first I want to acknowledge that stigma still exists in our health-care providers, as well as in the population. I think there has been lots of improvement and reductions in stigma because of a number of efforts that have occurred in providing education to providers on how treatments actually work for substance use disorders. So, for example, alcohol use disorder and opioid treatments are treatable, as you're saying; and harm reduction approaches.

So there's been a systematic effort within our knowledge exchange events, as well as in our educational programs in all health-care providers, including nurses, social workers, as well as engaging peers in the recovery.

We have this program called extension of community health outcomes, which really emphasizes and works on linking providers with specialists in educating around both treatments, but also recovery pathways. And we've done a number of different events. Our aim is really to recruit and ensure that people are aware of–not only in outpatient services, but on in-patient, as well as emergency settings, and really aiming to work on programs that really reach rural populations as well.

**The Chairperson:** Hearing no further questions or comments, I will now put the question on the report.

Auditor General's Report–Addictions Treatment Services in Manitoba, dated July 2023–pass.

Before the committee rises for the day, I would ask–the hour being 7:32, what is the will of the committee?

**An Honourable Member:** Rise.

**The Chairperson:** Committee rise.

***COMMITTEE ROSE AT:*** *7:32 p.m.*