Fourth Session – Forty-Second Legislature

of the

Legislative Assembly of Manitoba

Standing Committee on Public Accounts

Chairperson
Mr. Jim Maloway
Constituency of Elmwood

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Forty-Second Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON PUBLIC ACCOUNTS

Monday, May 16, 2022

TIME – 6:30 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Jim Maloway (Elmwood)

VICE-CHAIRPERSON – Mr. Greg Nesbitt (Riding Mountain)

ATTENDANCE – 10 QUORUM – 6

Members of the committee present:

Mr. Lamont, MLA Lindsey, Messrs. Maloway, Martin, Michaleski, Ms. Naylor, Messrs. Nesbitt, Smook, Teitsma, Wasyliw

APPEARING:

Mr. Tyson Shtykalo, Auditor General

WITNESSES:

Ms. Karen Herd, Deputy Minister of Health
Mr. Marco Essig, Provincial Medical Specialty Lead, Diagnostic Imaging, Shared Health
Ms. Janice Grift, Diagnostic Imaging, Shared Health (by leave)
Mr. John French, Executive Director, Diagnostic Imaging, Shared Health

MATTERS UNDER CONSIDERATION:

Auditor General's Report – Follow-up of Previously Issued Recommendations, May 2015

Section 9 – Taxation Division, Audit Branch

Section 18 – Senior Management Expense Policies

Auditor General's Report – Follow-up of Recommendations, May 2016

Food Safety

Taxation Division, Audit Branch

Senior Management Expense Policies

Auditor General's Report – Follow-up of Recommendations, March 2017:

Office of the Fire Commissioner

Senior Management Expense Policies

Auditor General's Report – Management of MRI Services – dated April 2017

Auditor General's Report – Follow-up of Recommendations, March 2018:

Rural Municipality of Lac du Bonnet

Auditor General's Report – Follow-up of Recommendations – dated March 2019

Management of MRI Services

Auditor General's Report – Follow-up of Recommendations – dated March 2020

Management of MRI Services

Auditor General's Report – Follow-Up of Previously Issued Audit Recommendations – dated March 2021

Management of MRI Services

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

This meeting has been called to consider the list of reports listed in the summary of committee information before you all.

I believe there's a prior agreement that the committee complete consideration of the following items without debate: Auditor General's Report–Follow-up of Previously Issued Recommendations, May 2015: section 9, Taxation Division, Audit Branch, section 18, Senior Management Expense Policies; Auditor General's Report–follow-up recommendations, May 2016: Food Safety, Taxation Division, Audit Branch, Senior Management Expense Policies; Auditor General's Report–Follow-up recommendations of March 2017: Office of the Fire Commissioner, Senior Management Expense Policies; then, Auditor General's Report–Follow-up of Recommendations, March 2018: Rural Municipality of Lac du Bonnet.

Does the committee agree to complete consideration of these sections? *[Agreed]*

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

Mr. Shannon Martin (McPhillips): Mr. Chair, I'd suggest two hours, and reassess at that time if we're not completed.

Mr. Chairperson: It's been suggested that we sit for two hours and then reassess. Agreed? *[Agreed]*

We will now consider the Auditor General's report titled Management of MRI Services, dated April 2017, and subsequent follow-ups.

For the information of the committee, Mr. Adam Topp, Shared Health CEO, is unable to attend this evening. Instead, Ms. Janice Grift, Diagnostic Imaging Program, Shared Health, is here as a witness.

Is there leave of the committee to allow Ms. Grift to speak on the record, if required? *[Agreed]*

Leave has been granted.

Does the Auditor General wish to make an opening statement?

Mr. Tyson Shtykalo (Auditor General): I–before I start, I'd like to introduce the staff I have with me here today. I have Stacey Wowchuk, assistant auditor general of performance audit; and Melissa Emslie, director of performance audit and the lead on this audit.

Mr. Chair, MRI scans help clinicians diagnose, monitor and treat patients' medical conditions. Delays in receiving an MRI scan can lead to delays in definitive diagnosis and appropriate treatment, and excessive wait times can increase patient anxiety and negatively impact quality of life.

In June 2016, there were 21,323 people waiting for an MRI, with an average wait of 23 weeks. At the time of our audit, we examined the management of MRI services by the Department of Health, Diagnostic Services Manitoba, Prairie Mountain Health and the Winnipeg Regional Health Authority. Specifically, we examined the adequacy of the processes for ensuring timely and efficient MRI services, and patient safety and quality of MRI scans and reports.

With respect to intake processes for MRIs, we found–oh, sorry–with respect to intake processes for MRI requests, we found that there were limited processes to prevent inappropriate MRI requests. This is despite evidence that 10 to 20 per cent of medical imaging exams are unnecessary.

We also found many duplicate MRI requests occur. In addition, wait times were imbalanced across the country. As of June 2016, the average wait time in Winnipeg was as long as 27 weeks, while the average wait time in Brandon was 12 weeks.

With respect to prioritizing requests and meeting related targets, we found that targets were often not met and some patients were given priority for non-medical reasons. These patients included Workers Compensation Board clients at one WRHA facility, due to an agreement between this facility and the WCB; patients covered by private insurers, such as professional athletes; and some patients with influence, such as government officials, donors and people waiting in the–people working in the health-care system.

We also found that facilities did not track MRI wait times by assigned priority level. For the output patient files examined, the audit found that only 42 per cent of urgent scans, 24 per cent of semi-urgent scans and 12 per cent of routine scans were scheduled when–within the target wait time.

With respect to making efficient use of MRI scanners, we found that scanners were not fully and efficiently used. The hours of operation for scanners in June 2016 ranged from 48 to 117 hours weekly. We estimated that nearly 11,300 more scans could be done annually if all 11 scanners ran 16 hours a day for every day of the week.

We also found that differing scanner protocol and scheduling practices were impacting the number of scans done per day. In addition, scanner productivity was inadequately monitored and more could be done to reduce the estimated 3,400 no-shows that occur annually.

With respect to reporting MRI results, we found that while radiologists' reports were generally prepared quickly after scans were done, we found some exceptions. This showed a need for better monitoring to flag any exceptions.

With respect to planning and performance reporting, we found that there was insufficient information for decisions on additional scanners. Performance information was inconsistent and incomplete and the information publicly reported needed improvement.

With respect to patient safety and quality assurance processes, we found that some patient screening forms were incomplete, facilities were accredited but the annual medical physics reviews were not done and peer-review quality-assurance processes were lacking.

The report included 24 recommendations at the time of our final follow-up in September 2020. Only six of the 24 recommendations were fully implemented.

Thank you, Mr. Chair.

Mr. Chairperson: Thank you.

Does the deputy minister, Ms. Herd, wish to make an opening statement, and would they please introduce their staff joining them here today.

Ms. Karen Herd (Deputy Minister of Health): Yes, I would like to. I'm joined today by Dr. Marco Essig, provincial clinical specialty lead for diagnostic imaging, and by John French, executive director, provincial diagnostic imaging for Shared Health, and Janice Grift, manager of diagnostic imaging, quality and process improvement, for Shared Health.

MRI scans use a magnetic field and pulses of radio wave energy to make pictures of organs and structures inside the body. In some cases, a contrast material–dye–may be injected to show images of organs or structures more clearly.

Manitoba has 14 MRIs located throughout the province: in Winnipeg, Selkirk, Brandon, Dauphin and at Boundary Trails Health Centre by Morden-Winkler.

Previously, Manitoba had MRI management split amongst Winnipeg Regional Health Authority, Prairie Mountain Health and Diagnostic Services of Manitoba. Since the establishment of the provincial health authority called Shared Health, MRI management of all sites has been consolidated into one organization, thus enabling better standardization and co-ordination of processes and procedures.

Manitoba Health and Shared Health are committed to ensuring patient-centred, safe and quality care in diagnostic imaging. Continuous quality improvement is imperative to ensure that we continue to meet the needs of individuals and adapt to ever-evolving medical evidence.

***** (18:40)

When the audit was conducted in 2017, the shift of management to one organization had not yet fully occurred. There were 24 recommendations, but because many were directed to more than one organization, it was identified as 52 recommendations across all sites, spanning six areas: intake of requests for MRI, priorization of MRI requests, ensuring MRI scanners are fully and efficiently used, reporting MRI scan results, MRI planning and performance reporting and patient safety and MRI quality assurance processes.

This shift to Shared Health diagnostics has enabled more consistency in implementing these important recommendations. The first follow-up occurred in March 2019, second in 2020 and third in March 2021.

While the pandemic has definitely impacted progress and momentum of rollout of the implementation related to the recommendations, we do feel that we are close to completing many of the recommendations that remain outstanding within the last follow-up. Considerable work continues in order to further strengthen and improve the rigour of processes and succeed in full implementation of the recommendations.

So thank you for providing us the opportunity tonight to share our progress to date and plan next steps on the audit. Thanks.

Mr. Chairperson: Thank you.

Before we proceed, like to inform those who are new to this committee the processes undertaken with regard to outstanding questions. At the end of every meeting, the research officer reviews the Hansard for any outstanding questions that the witness commits to provide an answer to, and will draft questions-pending-response document to send to the deputy minister. On receipt of the answers to these questions, the research officer then forwards the responses to every PAC member and to every other member recorded as attending that meeting.

Before we get into questions, I'd like to remind members the questions of administrative nature are placed to the witnesses. The questions will not be entertained if they're of a policy nature.

The floor is now open for questions.

MLA Tom Lindsey (Flin Flon): So we've heard now that Shared Health is the sole entity for doing a lot of this stuff with MRIs. So could you give us the status of the implementation of recommendations from the Management of MRI Services report? How many have actually been completed, and what's the status of the remaining recommendations?

Ms. Herd: Okay, this is fairly lengthy, but in terms of the audit items that were identified as work in progress at the last audit follow-up, March 31st, 2021, we can advise that on recommendation 15, Shared Health, working with all the different locations that have MRIs in the province, have, through the establishment of Shared Health, has responsibility for provincial clinical and preventive service planning for the health system, including the planning and operation of the province-wide diagnostic imaging program.

So Shared Health continues now to monitor actual daily progress against target to see where there are areas of MRI operations in the province that require some additional focus and attention. So that's recommendation 15.

For recommendation 17, in terms of new additional MRI scanners, again, we have the provincial clinical and preventive service planning process that identifies where clinical services will best be configured in the province, and as a result, then, Shared Health diagnostic imaging program can make the best decisions about where additional MRI scanners should be. And so in the most recent version of the Clinical and Preventive Services Plan, they've begun to identify that sites identified as intermediate hubs and full acute tertiary hubs should be locations where there are MRIs in place on a go forward.

Recommendation No. 20, that the department enhance public information on MRI wait times and volumes. This is an item that's actively under way. There's been work done with the new technology solution that's been implemented within Shared Health to ensure that we can begin to report wait times more consistent with national definitions through the centre for health information.

And work is actively under way with the Diagnostic and Surgical Recovery Task Force to ensure that we begin to report in more consistent national ways.

Recommendation No. 4, related to the length of time taking to book MRI appointments and promptly remedy any significant booking backlogs. This has now been implemented by Shared Health.

A new report has been implemented and ongoing work with all sites related to workflow is happening.

Recommendation No. 9, in terms of assigning priority codes to all MRI scan requests. Shared Health advises that WCB cases are dealt with in accordance to standard practice across other provincial jurisdictions and that these cases are imaged outside of normal operating hours and parameters from 4 to 6 p.m., Monday to Friday, and 12:30 to 2 p.m. on weekends.

WCB provides one week notice of any unfilled slots which are then utilized for routine cases.

Additionally, athletes requiring scans are dealt with in accordance with standard 'priorization' practices.

Recommendation No. 10, in terms of monitoring and tracking wait times by priority level and adjusting scheduling. Shared Health has identified that this is done through ongoing monitoring and improvement in terms of the ever-evolving way that efficiencies in the use of the MRI are monitored.

The alignment in Shared Health has helped to have consistent practices in place at all sites that have an MRI in place across the province.

Recommendation No. 12, in terms of identifying and implementing facility scheduling practices. Shared Health advised that they have participated in workshops to identify best practices in MRI scheduling and that they use ongoing monitoring and improvement to ensure that slate–spots for MRI appointments are used as effectively as possible.

Item 13, the recommendation about reducing no-show right–no-show rates. The dynamic is slightly different in rural Manitoba than Winnipeg. It's a much more complex thing to ensure that no-shows, those spots can be used in rural Manitoba. Of course, it's a little bit easier in Winnipeg where people can get to different MRI sites a little more easily. So Shared Health advised that they have been using overbooking in a way to ensure that we deal with the cancellations that just innately will occur.

Recommendation No. 16, in terms of MRI report turnaround times. There is always evolving evidence on this item. So Shared Health diagnostic imaging will always be assessing how the operations need to be evolve and evolving those appropriately.

In terms of recommendation 21, patient safety screening forms: the form has been developed. It's in the approval process and then the development of the process to perform audits on this needs to be established.

* (18:50)

Recommendation No. 23–we believe that this has been completed. This is the recommendation to have a medical physicist assess the MRI quality control programs each year as required by MANQAP, the Manitoba Quality Assurance Program, standards.

Recommendation 24, peer reviews for MRI technologists: Shared Health has implemented the recommendation 24(a), but we had not proceeded with the diagnostic imaging peer learning organization across Manitoba rollout. But now, post pandemic, we can move forward with this.

Again, the recommendations that were individually in that last follow-up report directed to Prairie Mountain Health and to WRHA, we can say that they are all being addressed through Shared Health's processes.

Recommendation No. 1, which was directed to multiple organizations working together: The department DSM, PMH and WRHA working together and collaboratively with Choosing Wisely Manitoba and other stakeholders, developed specific initiatives to improve the appropriateness of MRI requests. This is an ever-evolving issue. There's always evidence that emerges over time about appropriateness of MRI scans. And so this will always be ongoing work guided by evidence, but Shared Health advised that they are working closely on the Choosing Wisely initiatives that emerge in this field.

On recommendation No. 8, which was again directed to multiple organizations, to develop a single province-wide method of prioritizing MRI requests that include a clear definition and standard wait-time target for each priority level, at minimum meeting the Canadian Association of Radiologists guidelines. So, Shared Health advised that all but one site use these CAR definitions. Pan Am has slightly modified the definitions to meet their needs, and this is ongoing work.

Recommendation No. 11, working together to harmonize MRI scan protocols across all facilities in the province and adjust the standard length of scan appointments to reflect any resulting time savings: This is a very significant recommendation that, in my view, will have to be chunked out so that it could be accomplished. So, right now a certain number of protocols are currently identified by Shared Health for harmonization.

Recommendation 19, that the department work collaboratively with the various organizations to review and clarify how it expects MRI scan volumes and wait times to be calculated: We will–

Mr. Chairperson: Excuse me, I have to interrupt. I'm sorry, we have a time limit of 10 minutes, so we're going to ask Mr. Lindsey to re-ask the question so that it'll give you another 10 minutes.

MLA Lindsey: Thank you. If you could carry on with the answer to my first question, that would be greatly appreciated.

Thank you.

Ms. Herd: Okay, I think we just have one more. Sorry.

So recommendation No. 19, that the department will work collaboratively to review and clarify how it expects MRI scan volumes and wait times to be calculated and reported: So, the IT systems that are in place now allow us to move in the direction of reporting wait times more consistent with how CIHI, the Canadian Institute for Health Information, defines them, and we will work closely with the Shared Health organization, the regional health authorities and the Diagnostic and Surgical Recovery Task Force to focus on provision of the information that's most important to the public first in terms of wait times.

So that work is currently under way and we will be able to report more consistently with the national definitions due to the implementation of the new IT system.

Thank you.

Mr. Chairperson: Thank you.

I'm going to recognize Mr. Lindsey for his second real question, if he has one.

If not, we'd go to Mr. Michaleski.

Mr. Brad Michaleski (Dauphin): Thank everybody for attending and coming to answer these questions on this MRI report.

Just to give some context to this, if I reflect back to 2017, I think this was the first Auditor General report that I read after being elected. And, of course, we had a history in Dauphin of an MRI that took a very, very long time to get there. And I think I said at the last meeting–and I don't want to be–but I need to put this in context so I can answer the question. We were 12th or 13th of 14 in the province. And I would say our region and north–really, north of the Trans-Canada Highway, they lived without MRI services for a long time. They experienced a tremendous disruption when there was a significant amount of MRIs south of–in southern Manitoba.

Course, this was not just a–didn't seem to make a lot of sense why there wasn't better locations selected for MRIs earlier on. But that–having said that, you know, we can always still make changes to what's on the ground now, and that's partly what my question is about.

We see the MRIs are more in demand now. I don't–I guess I have one question: Are they becoming more mainstream? Are they becoming more

mandatory than they were 10 years ago? Ten years ago, they were–I wouldn't say they were a novelty, but there was new technology, you know, but now they seem to be more mainstream; they're more asked. So am I correct in assuming that MRI services are becoming a pretty critical diagnostic tool for across the province?

And, again, just the way the layout of the MRIs are now, it may not be the easiest thing to change the location of them now, but I do think that there's some logic to really studying where those MRIs are located or need to be located.

So I would–then I would ask–now we've shifted over to the Shared Health model. What does the future look like? Are we looking at just, for instance, a regional qualifier, I guess, for the MRI services the Province does, versus right now–let's just say there's a concentration of 10 in the city of Winnipeg. Now, does part of those ones in Winnipeg shift over to some other type of service–private, perhaps–while the Province moves the MRIs throughout the province? Is that what we're–what it's going to look like? Because somewhere along the line, there's a provincial responsibility to provide the MRI services, and that's not there right now–to have them in a better location in the province.

So I guess my question is, you know, what's in the window when–in terms of MRIs planning in the future with Shared Health? And, of course, there's new technology coming in MRIs as well that might change that landscape, too, and I don't–you know, I'm not sure what that's going to look like, but I want to be clear that there's a real emphasis on regional MRI services here. And that's what I–that's–my question is what's in the window here, and what are we doing to ensure that that happens?

***** (19:00)

Ms. Herd: Our–Manitoba's Clinical and Preventive Services Plan does identify for clinical services the importance of aligning diagnostic services to what the clinical services plan is. And, specifically, on page 79 of that plan, it does identify that MRIs, in terms of regional MRI hubs based on clinical programs, site location and volumes–that's really the planning parameters at a regional level, and that regional MRI hubs are also placed in provincial high-acuity specialty medical and surgical-care sites, again, based on clinical programs, site location and volumes.

But to your other question on clinical need and appropriateness, I thought perhaps Dr. Essig could provide further on that. *[interjection]*

Mr. Chairperson: Doctor.

Mr. Marco Essig (Provincial Medical Specialty Lead, Diagnostic Imaging, Shared Health): Yes, thank you very much for that introduction.

And just a little bit of background: I work in MRI since 1991, so I–it was established in '89. So I was at the very beginning when MRI was established. And it's evolving over time, of course. Like, the indications have grown; the indications have shifted. So, we have seen areas, diseases where we shift from CT to MRI, or from X-ray to MRI. But we also have seen other areas are shifting from MRI to other diagnostics.

So it's an–like, continuously evolving topic. However, like, the trend is that the demand for MRI has increased over time, substantially. Like, this is driven by an aging population in the Western world. It's driven by population growth. And it's driven by change in management from a clinical point of view, not managed by radiologists, it's jut that international guidelines on specific diseases now request to do an MRI instead of a CT or instead of an X-ray. That is driving that demand as well.

On the other side, in the past, like, certain population groups were not able to get an MRI because there were contraindications or the scan was taking too long. So, when I started in 1991, a typical MRI time was between one hour and one-and-a-half hours, the patient is in the scanner and trying to hold still. Of course, there's a certain group in the population that cannot do that, especially very sick patients or patients with movement disorders. So, that has changed. And the–but now, a scan is done in between 15 and 20 minutes, up to an hour, of course, depending on what kind of an indication we have.

So in general, we do see a trend that the demand for MRI is continuously growing and with Shared Health and combining all the organizations that provided diagnostic imaging in the province. We now have also the tools and the possibility to monitor. Like, we do know what the, like the projected growth is for–in the future that would also help us to identify the need for additional pieces of equipment.

And we have also, with the provincial organization now, the possibility of going after the postal codes to really see on–how patients in the province travel, where do they have their MRIs, where do they–from where are they coming, what's their wait time,

depending also on the locations where they are based from their home from the postal code which we can use.

And then, there's an–always increasing not only demand from a clinical point of view, but also from a technical point of view that we can apply MRI imaging to more people that we couldn't do in the past.

So it's a very, very dynamic process. But in general, like I said, like, a summary, the demand is growing.

Mr. Chairperson: Mr. Michaleski, for a second question.

Mr. Michaleski: Just to follow up, I appreciate both the answers on this.

I guess you reckon–in the Shared Health–or, the Shared Health report you're talking about, there's–it mentioned about regional, but what guarantees are there that that's actually going to be implemented? Because, again, there's–if I go back to recommendation 17, there's a whole bunch of data coming into here to try to select numbers, you know, in terms of locations and, you know, how we're going to manage these things.

Doctor, you mentioned the issue about that data may be tied to location, and that's part of the decision-making. And I would say to you when you're two to four hours away from an MRI machine, it's more important that you locate one there than the efficiencies 'eet' the provincial–than the efficiency at the provincial–than the efficiency at the MRI operations provincially, because that doesn't really make any sense, you know.

And especially in Manitoba, where you have Winnipeg, which is in the far, far southeast corner of the province, like, it makes absolutely no sense to, you know–and argue that all MRIs should be population-based, be–should be down there.

So, there has to be a regional component that has been lacking across health care on a number of things, but MRI is, in particular, it stands out as something that really, absolutely makes no sense whatsoever.

So, I–we still need a–you know, I'd like to have just on the record anyway, just that regional is absolutely important and you can–it's just–it's–simply can't ignore that, you know, and just use population or some other data to sort of say, okay, now they should all be down in Brandon or they should all be in Portage, right, because that makes no sense.

So, I would say, again, the location, then, to me, is sort of a first checkbox, right, so we're going to make sure we do that and then the other governing things will follow after that, right, but for sure we're going to make sure we do these, these, these things.

But, I guess my question then–again, MRI technology is changing and you've acknowledged that. And so, I'm going to go back to my original question, which talked about the provincial responsibilities and if there's a–can you give me some sort of a background or example of some place where MRIs have gone to–whether it's a combination of public-private–like, how is that–would that–how–would that improve, or is that a part that's part of the solution to the way the MRIs are sort of lined up in Manitoba right now versus how they should be? Like, does that private aspect play big into that?

Ms. Herd: In terms of private MRIs, when we've had discussions with other provinces and those private providers, what they identify is that it needs to be a long-term commitment for them to go through the large capital investment of putting a private MRI business in place in the province. And so, really, in Manitoba to this point, we have generally gone with the approach of a publicly supported system, although we know that some other jurisdictions have more of a mix.

I'd say, at the current time, we don't even have MRIs in every part of the province that has a hub or an intermediate hub emergency department and health-care facility. So, we haven't really even gotten to that sort of coverage yet.

Right now, the sites that are intermediate and district hubs that we have put MRIs in in the public system are at Selkirk, Dauphin, Boundary Trails; and in terms of intermediate sites, Brandon and, of course, the sites in Winnipeg.

So, there is more to do in terms of assessing where new MRIs might go, and right now I can say on the Diagnostic and Surgical Recovery Task Force, they're having these very sorts of discussions about–in terms of dealing with some of the backlog arising from the pandemic–what sort of model would be best placed to address those backlogs.

So, that's an ongoing discussion at the moment.

Ms. Lisa Naylor (Wolseley): Thank you, folks, for being here tonight to answer our questions.

I'm going to shift gears a little bit more towards the quality control aspect of things. I'm really

interested in recommendation 24 that talks about regularly completing all required peer reviews for MRI technologists and part B, implementing a formal and documented annual peer review process for radiologists that includes assessing how they prioritize, read and interpret MRI scans.

* (19:10)

I noted that you said that that was something that was not yet complete, but getting closer perhaps. I'm really conscious of the fact that this–you know, at 2020, at the three–after three-year review, this was a totally incomplete recommendation. So I'm wondering if you can talk to us about what some of the barriers have been and when we can expect to see these peer review processes in place.

Thank you.

Ms. Herd: Dr. Essig would like to answer.

Mr. Chairperson: Oh. Doctor.

Mr. Essig: Yes, so I can answer that because peer review is a big topic of mine.

And so, when that audit was done, there were very few jurisdictions in Canada that had implemented a peer review process for radiologists. Now, in 2022, they all have gone a different direction. They all have cancelled their peer review processes and went to, like, a theme which is called peer learning, because peer review is challenging because it's seen punitive and you would not engage individuals in a process that they think it's punitive.

So everyone has actually gone. There's still a review process, but it's not really a peer review on a regular basis. It's also taking into account that–like, there's other information where you can identify quality issues which are not part of a peer review process.

Peer review, just to give an overview–let's say you do 1,000 exams and, randomly, a certain percentage–1 or 2 per cent–are selected and they are reviewed again. So, it's like you're looking for the needle in the haystack in a way. And, of course, you can identify that people are underperforming, but there's way more other ways to identify by having an open peer learning environment which is not punitive, where people are allowed to step on and step forward and say, okay, there's an underperforming person. And that all flows into a–like, a central organization that looks into that learning. Like, taking these cases not to investigate but to learn.

Of course, you investigate them, but you use them as a learning opportunity. They are shared amongst the larger group, and nobody that is involved has to fear that there's, like, punitive ways.

Of course, there's then critical incidents, which are totally different, but they are also integrated into here.

So, again, there's an evolvement of the way on how we assess those, a way from a peer learning–a structured, peer learning process to a–like, a peer review process to a peer learning environment. And we have started that. I have created a document which is called diploma diagnostic imaging peer learning within Manitoba, which describes and outlines all these activities that we are doing and how we identify performance issues. It's predominantly made for radiologists right now but, of course, in the field of technologists it's going the same way.

So, there's a review process involved and there's also measures if someone is really identified to underperform, that this individual can be taken out and be trained and be mentored to improve in the quality.

Ms. Naylor: I'm going to make this a two-part follow-up so I can ask two things.

So, the one follow-up question is: you've indicated that this is–process has begun, so I'm interested knowing when this will be fully implemented across the system–the peer learning review that you've spoken about.

And, through this new process that you've implemented, what percentage of MRI readings would, you know, annually be reviewed to make sure that they were accurate and being done properly?

Mr. Essig: I can answer the first question fairly easy.

Like, the document was produced at the end of 2019, beginning of 2020, and you can imagine that there were a few other things that were more important in the last two years. But, of course, we are still reviewing, and we have started to look into that again.

Coming back to your second part, like, in a standardized peer-review process–like, there's different kinds of methodologies on what's the percentage of cases that you review on a regular basis. In a peer learning, it's very hard to define because, like, I was on MRI service today; I probably did peer review or peer learning in more than half of my cases, more than 50 per cent, because I look at the prior exam, I identify whether there was a discrepancy with the current

exam. So that's–it's kind of a review that we are using for learning, then. It's not standardized, but, like, we are now creating that environment where we can flag those cases and they are going into a learning or they're going into a review, depending on what kind of a finding it is.

So with a peer environment we are actually covering more. It's not, like, just ignoring 97 per cent and only reviewing 3 per cent.

Mr. Greg Nesbitt (Riding Mountain): Good evening, Ms. Herd, and your colleagues, there.

My question is about how can Manitobans feel confident that they're getting an MRI as quickly and as close to home as possible. I think we all know that delays in getting an MRIs scan can lead to delays in diagnosis and treatment for patients here in Manitoba.

So, can you just lead me through the process? Once I visit a physician and a physician requests an MRI, where does that request go to? Is it regional? Is it provincial? How and where are they prioritized? Is it based on medical need? What type of a protocol is applied there?

And also expand on how overbooking works and what happens if everyone shows up. It's something like getting on an airplane, right? They tend to overbook, and–but if everybody shows up, I've often wondered what happens.

So, thank you.

Mr. Essig: So, we have to differentiate here on how urgent the scan is. So if there's an urgent or emergent scan, physicians can send the requisition right to the site. So, for example, if a patient's in the emergency department at any hospital, they send the requisition directly into the department. The requisition is reviewed by a radiologist. The radiologist double-checks the urgency, often phones the physician back or there's even a phone call before they send the requisition. And then a protocol is established and the scan is done. For emergent scans, that's normally done within 24 hours, often even faster. So that's urgent ones.

There's certain urgent ones that have to change the location. So, for example, if I have a scan that is, like, an urgent patient in Boundary Trails but I don't have the technology to answer the question, then the scan will be done at a different site at, like, HSC or St. Boniface. Because the scanners are different–like, we are talking about–and I take the analogy of a car–like, we are running, like, very simple cars and we are running high-end cars, and, of course, they perform different.

And so there's certain scanners that–like, certain questions that can only answered at a certain site, and then the patient has to be transferred. The same is true if the patient needs immediate follow-up from the discussion and there's no physician, no surgeon that can operate on that patient, it often makes sense to transfer the patient to be seen by a specialist and to do the scan at the same time. That's in the emergent and, like, super-urgent kind of environment.

Urgent ones are normally then sent also to the site itself because there's also certain turnaround time. Everything that is elective or considered elective, depending on the discussion, goes to a central intake process. On that requisition, the referring physician can indicate whether they would like to see the patient at a certain site. There's a field where you can fill in, like, I want to have that patient scanned at Pan Am because I know that's where the experts for that questions are.

And that central intake process, the requisitions are reviewed by clerks, by specialists that are not physicians but, like, clerks that are specialized coming out of the profession that review those and then indicate what is the best site to go to if it's not specified, as well as distributing them amongst the wait time–the different wait times and so on.

***** (19:20)

And then the requisition comes. And every morning, if I go into the office, I find a stack of those requisitions and I fill them out. I give them a priority based on the clinical information that is provided. I also have the ability to say no, this is an indication which would rather go to a different technique–not an MRI, but a CT. And then the requisition goes back to the booking clerk at the site, and they book them into a schedule. That's, like, in a nutshell on–how the process works.

So, it's very different for emergent and urgent than for elective patients. And, of course, we have patients that have an MRI for a regular follow-up–for example, a cancer patient that needs, like, every six months a follow-up MRI. We try to do them always at the same site so that they get the same quality. And, of course, also in our organization, we would like to have the patient get the same quality independent where they go because patients might end up at one time at one site and the next follow-up is at another site. And I need to, from a medical perspective, make

sure–I want to have it the best–that they receive the same quality independent where they are going.

Of course, this is challenging, and that was also discussed in the audit, that we are not running all on the same platform. It's not that we have all the same machines. They are very different. They are different vintages. Some of them are 10-plus years old; others are brand new. And, of course, with that very fast-evolving technology, you cannot compare an old Chevy car with a high-end race car. Like, that's just not possible.

That's kind of how it's organized.

Mr. Nesbitt: So, we often hear of diagnostic wait times now.

Can you give me an average wait time for an elective MRI in Manitoba, and does it vary by site or is there a provincial average or site averages for each of them?

Ms. Herd: Okay, so right now–we do have these on our Manitoba Health website. So right now, the wait time–Manitoba average as at March 2022 is 24 weeks. That's the Manitoba average. We do identify the wait by individual MRI on that website as well.

I did allude to earlier, though, that we are just in the process of re-examining how we calculate wait times to be more consistent with the national definition of wait times. So, we do anticipate that there will be some changes to how we're reporting, but, of course, we want to make sure that we're going through a proper process of outlining how those changes are coming about and what the cause of them are. We want to be transparent about that.

So right now, on the wait–on the website, it's showing as an average wait of 24 weeks.

Mr. Dougald Lamont (St. Boniface): Thank you very much, and–yes, and hello.

I just had–I had a couple of questions to follow up on–it was a couple of the recommendations, and I'll try to talk about two of them.

I think one was No. 12, and I–correct me if I'm wrong–it was that the WRHA identify and implement facility scheduling practices that can increase the number of MRIs, that the WRHA participated in workshops. But, I mean, workshops aren't implementation. So, what would be the timeline on the implementation following from those workshops?

And the other was No. 21, that the WRHA implement processes to ensure patient safety screening forms are fully completed and properly signed. And if I'm correct, you said that that's in approval at Shared Health, but it has been previously done, that you said the WRHA developed and approved an audit form for use and that it advised that a committee had been struck to determine the process to conduct audits.

So just on those two questions: have there been implementation? Is there a timeline for implementation from the workshops about facility scheduling practices? And then for the safety screening forms, just where that's at and if the WRHA had already approved it, are we in a–in position where Shared Health is–has sort of backslid, so to speak?

Ms. Herd: We'd like Janice Grift to answer that.

Mr. Chairperson: Okay. Ms. Grift.

Ms. Janice Grift (Diagnostic Imaging, Shared Health): Okay. So, in terms of the scheduling, there are a couple of things. (1) It relates to the protocol harmonization, which is another one of the recommendations. So in order for the schedules to be the same, the protocols have to be the same. And so we're reliant on that piece, which we've identified a number of routine protocols that we can standardize. We're waiting for that approval.

The–there has been a lot of turnover, in terms of our booking clerks, and so that–it takes quite a bit to train them on–in terms of the booking processes and that kind of thing. So I'm hopeful that we can implement at least some of those protocols within the year. It's a challenge, certainly, with the changing staff.

The other question was related to–oh, safety screening–yes, sorry. So, it had–because there were three previous organizations that were audited, the WRHA had approved and implemented something, but then when we all fell under Shared Health, we had to make sure–that's one of the challenges, is trying to have standard practices across all the sites in the province.

So we continued with the WRHA sites, but we haven't quite implemented at the rural sites. We have educated the charge technologists to keep an eye on the screening forms because of how important they are. So the education is there, and next is just implementing the audit form provincially.

Mr. Lamont: Just–so to follow-up–and if one of the–it's basically a bottleneck that you're facing with staff turnover.

What would be the reason for the staff to–I mean, look, there's the–been a pandemic, we all know that. The–what would be the reason for a staff turnover? Is it–if you can address that in any way–what has been the challenge around retention or staff turnover? Because, I mean, clearly, if that were to be addressed you might be able to do this–it might be easier to make this happen.

Ms. Grift: Okay. So we've–a couple of things. We've had quite a number of unexpected retirements over the last few–or the last two years, I guess, because of the pandemic. Just–I'll be honest, it's been overwhelming at the front lines and dealing with the additional pressures and stresses, not only of the pandemic, but also of just the transformation and changes.

These are, you know, your lower level clerical staff, and so they're finding jobs that are a little bit easier and less pressure. So we do have some key people that are amazing and have stuck around, but they can only do so much. So I think it's just attracting people back into the health-care system at this level.

Mr. Martin: I'm interested in the recommendation for reducing no-shows in particular. In the original audit report, it noted that, unfortunately, in some instances, no-shows were filled with persons of influence, so politicians, athletes or large donors.

I see in the OAG comment that the WRHA participated in a pilot project to evaluate an automatic appointment reminder software. So I'm wondering if you can just walk me through that pilot program, when it occurred, how widespread it was and the result of the pilot project, whether the pilot project has concluded, and whether or not it's going to be expanded upon.

And I'm just thinking that my daughter–just quickly–has an orthodontic appointment tomorrow. I've already got a text, you know–two texts reminding me of that from that clinic, so.

Ms. Grift: Okay. So the pilot was done in–oh, boy, I want to say 2019. There was a number of sites within Winnipeg as well as Brandon, so we did HSC and the Grace MRI as well as Brandon. It was moderately successful because–because it was a pilot we couldn't integrate the software with our RIS, which would mean it–which would make it a much more robust system.

We did have privacy issues because of the fact that we can't say you have a specific appointment at a site because of privacy issues. So, there were a number of things we had to–hoops we had to jump through. The pilot was concluded, and as I said, because we couldn't integrate with our software, there were challenges.

* (19:30)

So, if we were to move forward with an integrated program, I feel it would be a much better solution. Right now, we have–it's on our radar, but we haven't been able to implement it further because we don't have the funding to implement it.

Mr. Martin: Another comment that I believe the deputy minister made was about 10 to 20 per cent of MRIs aren't required or medically required. I'm wondering if you can expand a bit on that, as to what's driving it; is it patient-driven or is it doctor-driven? And more importantly, how–or, can it be addressed?

Mr. Essig: Yes, so, just probably one little step back, like, what you said before about the no-shows. There's different kinds of no-shows. It's patients that forget their appointment or are just stuck in traffic, whatever, but there's also a fair number of patients that even–they undergo a screening procedure.

And that addresses the other question: there's no patient that goes into the scanner that had not a safety screening. That's just impossible, that will never happen. But then, during the screening procedure, they recognize that the patient has a contraindication for the MRI; they can't go. And these information, we don't have them hours before.

So there's certain times that, like, just the patient is not able to do it and then we have a spot available for half an hour. So, there's no patients walking around or sitting around that just wait for that to happen. That's why we are overbooking. And to answer your question, what happens if everybody shows up? We just work longer. That's just the–that's the simple answer. We produce overtime for our technologists at those sites.

And in respect of the appropriateness–like, appropriateness is a very difficult topic to discuss about because–like, if you ask 10 people, you will get 10 different answers what is appropriate or what is not.

There's certain things that have been proven, like through Choosing Wisely, for example, that certain indications, let's say, an MRI of the knee at a certain age would not be appropriate, but in–if you ask the referring physician, he says, yes, but this patient, like, I think it's appropriate. And then I need to have that discussion with him that I think it's not appropriate,

and this is an interesting discussion that we have to do actually every day.

But there's certain recommendations and we are working on those. So, we have implemented appropriateness measures that physicians have to fill out before they request an MRI of low-back pain. They have to fill out a form which clearly indicates why this patient needs it. And we are working on a project right now on knees or other MRI-specific indications where we know that there's a number of indications that are not fully appropriate. But of course, it–very much dependent, as everything in medicine, very individual in–like, dependent.

So, that number of 20 per cent, I think it's fairly high. And also, we need to see that most of those appropriateness criteria, they are calculated retrospective. So if you tell me that this is not appropriate for that patient, but this individual patient now has a pathology that I miss and he's improperly treated or not treated at all; it might be, from a general view, inappropriate, but I only know in retrospect.

MLA Lindsey: So I've heard you talk about the clinical services plan and how you're going to, through that, decide where other MRIs should be located. And you talked about some of the Interlake communities and southern communities. What I didn't hear you say anywhere was that there was any consideration for anything happening in northern Manitoba.

Now, recognizing that, perhaps, just placing one in northern Manitoba still leaves vast parts of the North without service, simply because transportation–I mean, you talk about somebody driving from Brandon to Winnipeg, it's a couple hours, as opposed to eight hours on a good day to drive from communities in the North; and in some cases, it's 14, 15 hours.

Even if you said, well, we're going to put one in in one community in the North, it still leaves so many communities with people with no way to access that. There isn't flights between them; there isn't bus service. So what's the plan for how are we going to address providing some level of service for people in northern Manitoba?

Ms. Herd: That's a great point you're making, and within the Clinical and Preventive Services Plan, there is a recommendation about planning for an intermediate hub in the North. It didn't specify location because of the vast distances, as you've identified. And so in order to ensure there are intermediate-level services in the North–so that's akin to something like a Brandon hospital would provide–there is a recommendation from that clinical plan that we need to go through a co-planning exercise with residents in the North, including First Nations groups, to identify what a northern intermediate hub looks like. Is it one site? Is it multiple sites? And from that clinical plan is where the–both the health, human resource and the infrastructure plan would flow from.

So the discussion is a live one in terms of where and what the intermediate hub in the North will look like and what the infrastructure requirements will be to support that in the North. So it is definitely a recommendation of the clinical plan.

MLA Lindsey: So, I hear you talking about a site in the North, and as I've just explained, a site in the North may not make it any more accessible for a goodly portion of the population in the North than having a site in Winnipeg simply because of the way to get folks from point A to point B.

So, one would hope then, that particularly looking at the North, that the plan may evolve into something more than just one site. Certainly, when you look at things like portable MRIs that have been around for quite a number of years now and have probably proven their worth elsewhere, that there's all kinds of other possibilities perhaps that you should be looking at, or I would hope you're looking at when it comes to sites, plural, in the North.

The other question I have about–specific to the North but may very well be applicable to other regions–is when we talk about missed appointments, is there any tracking system that shows why some of those appointments have been missed? Is it because of missed flights, missed bus service, inability to actually get from the North to wherever the MRI has been scheduled for, weather conditions and all of those kind of things? Is there a tracking system that covers all of those off so that then you start building the case why there needs to be MRIs in other locations, particularly the North?

Mr. Essig: We follow up on every patient that is not showing up to see why they are not showing up, and also even more patients that are coming delayed, specifically if they're coming from the North or from outside of Winnipeg or they have to transfer from site A to B. Then, like–they are still accommodated to a later time point and we re-juggle our schedule during the day.

Like, there's so many reasons, of course–we know–why a patient didn't come; whether there's a

tracking system where it's really like that. I–I'd, like, out, like–I can't tell you, like–so many percentage it was because of weather or because of transport or whatever. That I can't answer. But we follow up with every patient that doesn't show up.

***** (19:40)

Mr. Dennis Smook (La Vérendrye): Thank you for attending tonight's committee.

And some of my questions have been partially answered, but I'd just like to go on the scanners being fully and efficiently utilized. I know that Shared Health is in its infancy, and that's the–one of the directions that Shared Health has to make sure that they get utilized. I'm just wondering if there's any type of numbers. Like, you know, it says that the machines are running at about 16 hours a day. I don't know how many scans that would give you, but how many scans are done in a day, and are there a number, whether it be 10 per cent or 8 per cent or 2 per cent, that don't get used because of no-shows or whatever else is happening?

It–just going from an issue that I had a few months back where I had an MRI, and I got my letter stating when I'd have–when I was scheduled, and that was quite a few months in advance, and then about two weeks later I get a phone call, you can come in; if you can come in next week, we can do you next week. And I asked why is it so fast, and they said they can't get a hold of anybody; nobody's returning their calls. Is that an issue with some of this scans and stuff?

Are we not being fully utilized or efficiently utilized because they're just not being–people aren't showing up? I know we've talked a bit about no-shows and that. Like, how severe of a problem is it? Like, are the machines running at 98 per cent, so really it isn't a problem, or are they running at 70 per cent, and that's a big problem?

Mr. Essig: It's, again, a very complex question.

In general, like, looking at the landscape in Canada, Manitoba runs their scanners at a high capacity overall, on average. But you need to see that, let's say, for example, the scanner in Dauphin does 2,000 exams a year; the scanner at Pan Am does 12,000 exams. So, you can answer which one is the most efficient one. It–so many factors that, like, depend on it, the patient makes it, the location, the catchment area.

Of course, in more rural areas, an MRI cannot run efficiently; there's not just enough patients for that scanner, and you cannot force patients travelling like, let's say, from the very south of the province into a northern community to get the MRI. You can do it for an individual, a few, but it needs to be a kind of a balance. And that also, then, answers or kind of partly answers the question, how efficient we are doing.

In general, like, looking at the general landscape, we are running them at a higher rate than other provinces. Also, like MRI, we have 14 scanners, and they are–if they're all running 100 per cent, if one fails, you really have a problem because where should you send those patients? So you can never run it 100 per cent; that's unsafe for the site and for the patient population.

So, we are running them very efficiently at a high percentage, but it really depends on what kind of a scanner, what's the location, what's the patient mix. And then, of course, how is the staffing? That's another huge problem. Like, we only can run the scanner if we have staff to run the scanner. And, like, especially during COVID and in the last couple of years, like, there were times where we had not enough staff, and then you get an appointment in three months, and then suddenly we–there's more staffing available because there's less people sick, and then we open up schedules. Like, we open up weekends or we open up evenings. We even, at certain times, had the scanners running overnight. So you could get it–at 2 a.m. you could get an MRI appointment. And that really depends on what we have as a capacity.

So, we try from a system to run as efficient as possible, but it also very much depends on staffing. And if you have the staffing, of course, we open up those shifts that are normally not filled because of staffing issues.

Mr. Smook: I thank you. That answers my question.

I would just–I had that concern because when we look at all the number of recommendations and stuff, how big of a problem it is, but obviously it's a problem but it's not as critical as what it may seem.

Thank you.

Mr. Mark Wasyliw (Fort Garry): I'm wondering if you could expand on the staff vacancy issue because that's clearly a challenge that you're facing.

What is the current vacancy rate? And if we were at full capacity, how many more, you know, tests could we get through the system?

Mr. John French (Executive Director, Diagnostic Imaging, Shared Health): We have a vacancy rate of

around 10 per cent for MRI staff currently. However, the number of MRI staff that we have in the system is relatively small, so it's subject to sudden and quite dramatic variation.

As an example, we recently lost just a couple of staff from our site at Boundary Trails, and that led us to have to close down some shifts there because there's only about four staff that work there, okay. So that's a challenge that we have in highly specialized areas.

We are working with the colleges to make sure that we can train the number of additional staff that we need to run the system effectively, and we're trying actively to get more staff into the system, but it will continue to be a challenge while we have a small number of specialized staff and some fairly long lead times to train those staff.

Mr. Wasyliw: So, you had indicated that the current sort of average wait time is 24 weeks. I suspect that that's not best practices or what you would consider ideal.

What would be the target wait time that a fully resourced, properly run system would find, sort of, as reasonable, that that should be our target, that that's where we need to head? And how much more staff would you need to get there?

Ms. Herd: Sorry, Dr. Essig would like to speak to the priorization, and then Mr. French to some of the staffing answer.

Mr. Essig: Yes, so, wait times–and a lot was discussed in the report and there's a–like, a very current–and a member of the task force–discussion about the wait times, what is acceptable, where we should we go, what would be the end goal.

The good news is that, like, a patient that urgently needs an MRI, there is no wait time. Period. Every patient that needs an urgent MRI in the province of Manitoba will get it within 24 hours, unless a site is down. That's like the–there's these very few exceptions.

Patients that need an urgent MRI, and we are talking at the range between three days and seven days, they will get their MRI. There is no wait time for those patients either.

The wait time is really for the elective patients. There is national targets that are set and, of course, here we can compare us with other jurisdictions. And again, in those patients, even, there is patients that 24 weeks doesn't really matter. But there is others in that same group where it matters, where it might have an impact. But we don't know that in advance; it's, again, like a retrospective analysis.

And I would therefore, like, ask Janice or Mr. French to answer about those national benchmarks, because they have done all those calculations for us.

Mr. French: So, this is the second part of the question, I think, around the wait time standards, and also around our staffing requirements. So, I–the recommended wait time for elective cases would be about 60 days or 8.5 weeks.

Now, I should qualify something about the wait times that were reported earlier, in that they are not the average length at which patients wait; they are the average wait time for the next person to come onto the queue across the province. So, many, many people wait less than that 24 weeks. So that's important to clarify that.

In terms of our staffing requirements, through the work that we're doing with CPSP and through the wait-list task force and so on, we estimate that we'd probably need in the order of about 11 or 12 additional FTEs to drive down our wait-lists. But the number of people that you need to achieve those FTEs would be more than that because, of course, you have to cover vacation relief, sick time and so on. So it's probably in the order of magnitude of about 15 to 16 staff members additional that we need within the system.

* (19:50)

Mr. James Teitsma (Radisson): All right. Thank you very much for being here, and I thank the member for that question because he did get a couple of my points added–or asked and answered there around the emergent and the urgent wait times as well as maybe what–speaking a little bit to the bottleneck.

But if he could also just give us a sense of, you know, what percentage of MRI scans are emergent, what percentage are urgent, what percentage are elective, and then I think you said there was a fourth category of kind of regularly scheduled–or maybe that's elective regularly scheduled cancer follow-up and things. So, a breakdown of those four would be helpful for me.

And what I think ended with in our preparation meeting that we had last week was trying to understand, from a flow perspective, you know–I think a number of my colleagues have talked about they want a scanner here or another scanner there or more scanners or–and they think, you know, the

number of scanners is the limiting factor. You suggested that staffing will also play a role.

And so I'd like you to just kind of go through all the components of what it takes to perform these MRIs, so that scanners, technicians, radiologists who read the scans, you know, patients showing up, budgetary dollars, hours of operation, right, all those various components you have available to you on the planning team. Which of those do you need to move in order to achieve the benchmark, the ideal outcomes that we're looking for?

Mr. Essig: Yes, it's a very, very difficult question, especially if you want to have a breakdown on the categories. Like, we have P1, P2, P3, P4. It depends very much on the site. Like, if you take, for example, HSC, you can have up to 25 per cent in a day which is P1, emergent, because that's where a lot of these emergent MRI indications ending up to get care. If you go to a site like Pan Am, they almost have zero. They have almost 100 per cent, kind of, elective cases. And if you go to, like, let's say a standard site, you could say that probably about between 3 and 5 per cent are urgent; about 10, 15 per cent emergent; and then you have a fairly big block that has regular scheduled MRIs for follow-up; and then you have the elective group.

But, as I said, like, it really very much depends on where the–like, which site. So, for example, HSC on a Monday morning, you don't schedule regular patients because we know over the weekend there's an accumulation of in-patients, emergent patients, that we don't even schedule regular patients anymore at that site for the Monday morning and only fill those needs because we wanted to meet the targets that are set for turnaround time of patients.

In respect of the second question, of course, it depends on the number of pieces of equipment that are available, and we have very good data that outline the number–the population in Manitoba, the estimated population growth, health factors that, like–change in clinical practice, that play into that which shows an increase of about between 3 and 6 per cent per year that we have seen.

And, of course, then we know that's the capacity in the system, taking into account that these machines cannot run 100 per cent. They need maintenance. You will run them out if they are running too fast or too often. Like, many, many factors are playing.

So we know exactly when we hit that time where we need to bring in a new system. Of course, the new system needs to come with operational dollars. Maintenance is a huge issue because we are fairly isolated;, like, we have created a group of technologists and engineers that they do the maintenance on site so that we don't have to fly someone in from the US or from other jurisdictions. That has all taken into account. There's operating dollars for that.

And then you need normal replacement cycles. If you replace a scanner, that's not done in a day. That needs sometimes weeks or even months, depending on how much construction work is associated with it.

And then, of course, you need operating, like, really, individuals that run those scanners, and that's, again, depending very much on where you have those individuals available and, of course, certain locations in the province are challenging to staff.

Mr. Teitsma: Just a quick follow-up, and I just want to make sure I didn't catch it wrong. You said three to–at a regular site, 3 to 5 per cent urgent, 10 to 15 per cent emergent. Did you mix those up? Yes? Yes, as you–well–I see Ms. Grift–*[interjection]*

Sorry. I see Ms. Grift nodding in–already in the background, so we'll get back to that.

But it sounds like what you're saying is, yes, we will need more scanners. Yes, we need more techs. You did not comment on the number of radiologists in the province and if there's a need for additional capacity there. I'd appreciate if you could comment on that, and then, you know, you said you had some operational dollars as these new scanners and texts come online is what will be needed as well.

But just, yes, if you could comment on that, or Ms. Herd.

Mr. Essig: Yes. So, in respect of radiologists, there's a–like, they have increased substantially because of the increasing number of work. We have also changed to provide shift work now. Radiologists are not working from 8 to 5 anymore. They work from 8 until 11 and then there's call coverage. So on site–really on site. And then also some specialized, so that the scan is also read by the proper radiologist. That's very important as well, specifically if we have very complex questions coming out of oncology, neurology, stroke and so on.

So, there's a–but, because the radiologist's fee for service, they are contractors to the system, and that's my role as well, as the provincial lead, to make sure that there is enough coverage that these turnaround times are met. So, there's certain turnaround times on

how long we are allowed to–like, how fast we need to read that scan, and that was in the–like, was assessed in the audit as well, and we meet those benchmarks.

Actually, we exceed those benchmarks in most of the areas, with very few exceptions, which is pediatrics, for example, but pediatrics is very different because those are very complex cases. You often have them sit and you revisit them not to make a wrong diagnosis, which would have a huge impact on a child.

Ms. Naylor: I can hear that there's quite a lot of complexity about staffing, from what Mr. French and the doctor shared with us. But I'm wondering if it's possible for the department to share with us the vacancy rate broken down by RHA for–with–for all staff required to operate MRIs in Manitoba. Is there–is that tracked? Do you have access to the vacancy rates by RHA?

***** (20:00)

Mr. French: So, all staff fall under Shared Health, would be the first observation there. So we don't have breakdown by health authority as such.

We are able to look at where our specific current problems are, and particularly for MRI–and it's a small number of staff members, as I mentioned earlier. So we know we have acute problems, currently, in Boundary Trails, in Selkirk, in Brandon and, to a lesser degree but not insignificant, in the Winnipeg area as well.

So, we can answer to that degree.

Ms. Naylor: And just to follow up–thank you for that, by the way. And just to follow up, building on your previous comment about the need for 11 to 12 additional FTEs across the system or 15 to 16 additional staff–and I hear that there's some barriers in staffing in certain regions–but is–are–is this also a fiscal barrier?

Is there money in the budget for these positions and they can't be filled, or is there not money in the budget to fill these positions–to fill what's needed?

Ms. Herd: We have–as part of the Diagnostic and Surgical Recovery Task Force, we've established a budget that will be available to be used for both the surgical backlog and MRI. I know Dr. Essig is a member of the steering committee.

So, right now we have the project team at work on the proposed allocation of that funding, and so some of that work is currently ongoing in terms of what resources are needed to address–I think we've heard more about the surgical backlog, but the MRI-related backlog as well.

Mr. Michaleski: My questions are specifically on recommendation 17. That's directed to the department.

I think, just reading this thing–like, the recommendations made by the Auditor General–I find this recommendation probably the most–one of the most important ones in the whole report, because it is talking about data. And this is kind of in-line with what Mr. Teitsma was talking about. And I can appreciate that this–the data is–can be very complex for planning.

But recommendation 17 talks specifically about a new decision-making process. And it also–on a number of bullets, it's talking about the volume of MRI demand. I think we've touched on that earlier. The various proposed scanner locations. I was talking about the cost-benefits of expanding the operating hours, then we talked a little bit about that.

But it does, specifically, at the–the Auditor General's recommendation is the department advises it will work on developing a new decision-making process–or, a formula for MRIs.

So I guess my question is: Where is this at, in terms of a–and again, I understand there's a considerable amount of moving parts there–here. But is there a definitive date where you need to have a formula, you know, in terms of where they're going to be located? Like, where is that? And the working group that's compiling this information on the decision making and the recommendations, who comprises the people that are providing input into this formula or process?

Ms. Herd: There's actually a few different processes in place that address MRI investments.

So, the first is the Provincial Imaging Advisory Committee, and that committee is the one that provides advice to the government on replacement equipment. So, because that Provincial Imaging Advisory Committee is comprised of radiologists, they're the experts in the field that inform Manitoba Health if the performance of an MRI is maybe hitting end of life and subpar. So the replacement equipment goes through that process.

The second process is the Clinical and Preventive Services Plan. So that Clinical and Preventive Services Plan process is the new one that was created with the establishment of Shared Health. So, Shared Health

is required to work with the five regional health authorities, CancerCare Manitoba and Shared Health, Health Sciences Centre, to identify where surgical and other specialty programs are going to be established, bolstered, strengthened so that it can determine where net-new MRI equipment would be required in the province.

So, at this point, as I mentioned earlier, there's no MRI equipment that's been yet identified through the CPSP, but once the northern intermediate hub discussion concludes, in terms of whether it's one location or multiple locations, that would undoubtedly provide information on what sort of investment would happen in northern MRI equipment.

And then the third place where investment decisions and information would come from is from the Diagnostic and Surgical Recovery Task Force. And that group, their mandate is to deal with recommendations and solutions to address the backlog that's arisen from the pandemic. Dr. Essig is a member of that steering committee, and so information on investments related to dealing with the MRI backlog will also come from there.

So there's three different processes: the PIAC process–Provincial Imaging Advisory Committee–is for the replacement; the provincial clinical planning process is for new MRI locations; and then the surgical and diagnostic task force is related to the backlog.

Mr. Michaleski: Just one short final follow-up question.

Regarding the Shared Health–the second point you were talking about, what's–it's a combination–Shared Health, the five authorities, Health Sciences Centre and that's where new ones will be going, correct?

So, I guess–from Dauphin, we're within the Prairie Mountain Health region, which extends from Brandon all the way up to Swan River–large area of the province. So what–can you tell me if there's an effective Parkland voice on that steering committee? Because it is pretty heavily weighted against our region, so I just want to make sure that, you know, that Parkland is getting representation.

Ms. Herd: So, on the Provincial Clinical and Preventive Services Plan, there are provincial clinical teams. And the design of the teams was made to get at that risk that you're identifying. So the–each team is made up of the provincial clinical specialty lead, which generally tends to be a person based in Winnipeg, and the other co-lead of the team is normally a health expert from one of the regions outside of Winnipeg to try to bring–ensure that the planning processes do not–aren't Winnipeg-centric, if you will.

So the makeup of the team and the composition of the–of each provincial clinical team is intentionally done that way so that there's representation from each of the seven service delivery organizations–so, the five regional health authorities, CancerCare Manitoba and Shared Health.

MLA Lindsey: I want to follow up a little more on some things you said earlier about WCB and other special-interest folks that access MRIs. So, you said that for WCB, the plan is they will do it for them in off hours. So my question, then, is if there's people there manning MRIs in off hours–or not really off hours–so what makes WCB jump ahead of the queue for other people that are waiting for MRIs?

***** (20:10)

Mr. Essig: Like, in general, like, WCB patients do not jump ahead, really, because they are scanned at times where these scanners are not operational, where we don't have operational funding for those scanners. And so, yes, it's just–there's a contract with WCB, and the patients–or like, these individuals–like, whether you call them patients or individuals, they are scanned at times where the scanners are not used, where we don't have funding for the scanners. It's not that we push out other patients and have them put into that slot; it's just a slot that it's not scheduled for.

MLA Lindsey: So there's no operational funding, so WCB, in essence, becomes a private health-care funder in that they pay for the technicians and whatever's required to be there on overtime? Or how does that exactly work, then, if there's no operational funding but, in fact, they are operating? How does that work?

Ms. Herd: What the–this would've been the WRHA at the time. When they first moved forward with this arrangement with the Workers Compensation Board, there were discussions between the board and the Winnipeg Regional Health Authority to identify a way to provide or problem solve this issue that WCB had raised to the WRHA that very often they had clients that were waiting longer than they would like for an MRI and that oftentimes the MRI was needed to help in the diagnosis of how to have that individual get back, you know, on their recovery so that they could re-enter the workforce.

And so at the time–this is quite a few years ago–the arrangement was that they would enter into a contract with the WRHA. So now that contract is with Shared Health, but they would enter into a contract with the WRHA to pay for the cost of operating the MRI outside of their regular hours of operation. So, at that time–and I believe this was the Pan Am MRI–the arrangements were for 4 to 6 p.m., Monday to Friday, and 12:30 to 2 p.m. on weekends.

Mr. Smook: I know these reports are in regards to MRIs, and I know technology is changing quite rapidly, and I think the comment was made, like, some of the older MRIs are like an old '54 Chevy and the new ones are like a 2022 Cadillac.

Is the technology itself for MRIs changing, or is it just the equipment technology that's changing, that MRIs will be around here for another 30 years or–like, I've heard of scanners like a PET scanner or something. Is there different technology that may be replacing the MRIs at one point? Like, I know that all that we had years ago was X-rays, and then there was CT scans and then MRIs. Whereabouts are MRIs in today's world of technology? *[interjection]*

Mr. Chairperson: Dr. Essig.

Mr. Essig: It's–oh, sorry, I–

Mr. Chairperson: Dr. Essig.

Mr. Essig: I'm happy to answer that.

MRI is evolving. It's still the same technology when it was developed and, like, the Nobel prize was given for the development of the technology. So, the base technology, it's still the same.

What has changed, what have made MRI more efficient, faster, also opening it to other indications–so, for example, in the past we couldn't image moving organs. So, you couldn't image the heart, you couldn't image the lung, and even the abdomen was difficult because, like, with breathing you are moving, and movement kills the quality of an MRI.

That was a lot of–that was computer technology and technology to detect that signal. Like, you activate the body and the body sends a signal out, like, just very–in a nutshell, and the signal is detected by an antenna. So, the antenna technology has improved. The way on how we can process those data that are coming out has become much faster.

So, it's computer technology and general technology in high-frequency physics that has made the scanners faster and opens those MRIs to way–other indications than when I started in 1991. That–like, it's really tremendous. That time, you could only image the brain and the spine; that was all. All the rest was kind of not possible to really scan properly.

Sure, there are indications that–moving away from MRI. For example, you mentioned PET–PET imaging. But there's way more indications that go into MRI because we have now the possibility to scan faster, to scan more body areas and also to look into, like, a different dimension, which we haven't been able to look for.

When MRI started, we looked at anatomy, like a slice through the body, and we then see how–what is inside. Today, we measure the blood flow; we measure the viability of the tissue. There's so many things that we can measure. So, for example, if an acute stroke patient comes in–like, about, like, three, four years ago, we didn't scan patients with a stroke with MRI. Now, every second patient with an–a stroke gets an MRI because we can tell whether the stroke has already destroyed the brain or whether they–we can, with modern therapy, like, recover that brain tissue that was affected by a stroke. And this is only possible since a few years, and, of course, that had increased those indications.

So therefore, like, there's–still MRI is the method of choice for many diagnostics and it has got 'influent'–or influx from CT, from–even some PET indications are now done with MRI, or can be done with MRI, and other MRI indications go to PET. It's kind of–it's continuously changing, but MRI is still the modality of choice for a lot of indications.

And, like–and that's more like a negative statement I have to give here. We haven't even–because of capacity issues, we haven't even opened certain indications for MRI that are standard in other countries. For example, breast cancer. In many jurisdictions, patients with breast cancer get an MRI today. We can't offer it because we don't have the capacity. The same is with prostate cancer. There's sites in Europe that run in–whole MRI with prostate almost every day. We really don't offer it because we don't have the capacity because in the–like, the priority of indications, they are sitting fairly low, but they are becoming slowly the standard of care across western countries.

Mr. Lamont: Yes, I just–a question.

You mentioned the Wait Time Reduction Task Force. If you could just provide just some details about how–I mean, they must be considering, or I

hope that they're considering this report as well, just because, clearly, that this would, I assume, inform their ability to–this is–a lot of the work's been done, so to speak, in terms of bottlenecks and challenges.

So what is the–how does the wait times task force fit in with this?

Ms. Herd: There's actually been quite a few reports that we've referred to the Diagnostic and Surgical Recovery Task Force.

* (20:20)

So there was a 2017 wait time reduction fund report that's been provided to them. There's–there has been the reports from this OAG audit, and then really anything that we come across that we think may be relevant information for them in their planning we do provide.

So, for example, just as we were preparing for this day today, there was a study done by CADITH, the Canadian Association for Drugs in Technology and Health, that had recently done a report on medical imaging, so we provided that to them. Even the CIHI report on wait times from last week; like, really anything that sort of hits the radar, we do provide to them so that they incorporate that into their planning.

Mr. Teitsma: Just getting back to the backlog and the capacity–and I appreciate the projections that you're making and how you can see a need for greater capacity or for additional indications that might increase capacity–but when I look at it as a system, you know, a year ago–or today we said the backlog was 24 weeks. You know, 10 months to a year ago, it was somewhere in the 23-to-30-week case. So that, to me, suggests that we actually have sufficient capacity, or at least this year we did, because our wait time at the beginning was the same as the wait time at the end.

Now, I can appreciate that I'm being simplistic and I'm probably missing something, and that's what I'm asking–the question is, what am I missing? Am I missing anything? Or is it that patients are dying, that patients are leaving jurisdiction to get the scan done elsewhere and leaving–and getting out of the list? Or is it just simply a matter of, you know, if we eliminated this–if we had eliminated the backlog–you know, taking COVID aside–if the backlog has been relatively stagnant year after year, if it was 18 weeks five years ago and then 20 weeks four years ago, you know, all pre-pandemic, if it's as simple as just getting those 10 weeks or 12 weeks out of the way and then having the capacity? Like, what am I missing? Why is–or is it, in fact, that simple, that we're that close to being successful because we're able to maintain that relatively stable wait time?

Ms. Herd: We do have information on the waits on the Manitoba Health website and, again, it's a point in time and it's a–the–our methodology that we've been using for many years is a prospective wait.

So, back in March of 2021, the average was actually up at 31 weeks. It's varied over the year. It's dropped as low as 18 weeks during some of those months of 2021. At March of 2022 it was up to 24 weeks.

We do think that there is also some pent-up demand from people having deferred even just going to their family physician for an annual checkup and that there will probably be some uptake in catch-up with delayed care.

What has been discussed at the task force–at the Diagnostic and Surgical Recovery Task Force–is defining the backlog. So, I've heard Dr. MacDonald, the chair, say that their mandate on the task force isn't to take the 24 weeks to zero, it's to take the 24 weeks to what the wait was pre-pandemic. So, that's some of the work that they've been working on.

We've seen Doctors Manitoba and others talk about sheer numbers, but I think what we've heard Dr. MacDonald say most recently is that the task force would prefer to focus on waits because that's the thing that matters the most to patients.

So, right now they've been doing that analysis on what would address the wait times to get at pre-pandemic levels.

Mr. Teitsma: Just *[inaudible]*, you know, I very much agree with the push to use wait time as an indicator. Using numbers of procedures as an indicator is completely meaningless. Saying there's 100,000 people waiting for a procedure that should be, you know, done in one or two months, and then you find out that the pace is actually 50,000 a month, there is no wait, right? Like, that's actually perfect. But there's no way for an average individual to be able to process those facts and kind of–and parse it, whereas if you had a wait of only 80,000 but it was getting done at 2,000 a month, well, this is a huge problem, right. And so it's not just the wait–or, not just the number, but it's the rate, and those combine to create the wait. So, the wait is the thing to focus on. I appreciate that.

But if you could maybe more just directly answer the question of, if the backlog is largely static over

these years, does that indeed suggest that that capacity's close to what we need, or do you think there's something else going on in the system that's easing the backlog?

Mr. Essig: Yes, there's multiple factors at play here.

First of all, I said before that technology is evolving. So, we have been able to replace some of our very, very old equipment, which brings more efficiency in the system so we can do more scans per day. That, of course, is one factor.

We had added a net-new piece of equipment over the last couple of years, and we had–like, especially during the pandemic, we really–because at the beginning of the pandemic, so many scans were cancelled and the wait-list was going through the roof, we added capacity, like, asking for overtime, got overtime funding and have added shifts to–as I said, like, we were running scanners at night, even, to bring that down to a level which is acceptable, or close to.

It's still far away from what should be the standard, but at least to not have patients wait too long, because with every wait time, you, of course, have an impact on your diagnosis and, finally, the outcome.

Mr. Chairperson: We are now only three minutes or so to the suggested end, and I only have one other questioner on the list. If there's more, let me know.

But Mr. Lindsey, would you like to ask a quick question?

MLA Lindsey: Certainly.

So, I've heard you say that it's part of the clinical services plan as to what areas are going to get MRIs. I guess, who gets to have input into making those decisions, and when can we expect those decisions to be made?

Ms. Herd: So, the Clinical and Preventive Services Plan, the first version of it which came out in–actually, before the pandemic, it had–there had been over 2,000 health-care providers that had had input into that plan. There also was pretty significant outreach with the Association of Manitoba Municipalities, with First Nations, Métis and Inuit groups. All these things are that we're trying to make it as inclusive a process as possible.

Recognize there's always more room to get other input and views into the clinical plan. Over time, the plan is that the Clinical and Preventive Services Plan will be refreshed on a regular basis by Shared Health in conjunction with all of the major service delivery organizations. But there's really no end to the amount of discussion and engagement that we can undertake on the clinical plan. So, you know, we remain open to other ideas for input.

Mr. Chairperson: Mr. Lindsey, for a quick follow-up.

MLA Lindsey: So, the last time I looked at the clinical services plan–and, to be fair, it was a while ago the last time I looked at it–there was very little detail on anything in relation to what was going to happen in the North, whether it was a regional centre or sub-centres. None of that detail was in the plan then. Has that changed now?

***** (20:30)

Ms. Herd: So, the plan is a guidepost, so it's–tries to outline the broad parameters by which individual organizations would do their detailed planning. So, we've talked about plan provincially, deliver locally. So, we would want to ensure that the northern RHA is using the principles in the plan of care closer to home, trying to focus on establishing major sites that can deliver a broader array of services.

So all those things are information that the individual service delivery organization–in this case, northern RHA–should build into its annual planning processes. So you'd see a lot more level of detail at the northern RHA strategic and operational planning level. It's trying to ensure there's alignment to the provincial plan, but done at a more granular level at the region.

Mr. Chairperson: Thank you.

Hearing no further questions or comments, I will now put the question on the report. *[interjection]*

Okay, so we have used up the two hours that we agreed to, and so we need a recommendation from a member of the committee that we actually deal with the questions that–because we're out of time.

Mr. Martin: Mr. Chair, if I can recommend the member for Riding Mountain (Mr. Nesbitt) offer one short question and then we conclude?

Mr. Chairperson: Okay, what is the will of the committee here, then? Do we agree with that?

An Honourable Member: Agreed.

Mr. Chairperson: Agreed?

Some Honourable Members: No.

Mr. Chairperson: No?

Mr. Michaleski: I would just ask that Mr. Nesbitt have a question. I also have one more question, as well, if I can–if we can get those in.

Mr. Chairperson: What is the will of the committee? Agreed?

An Honourable Member: If we're all going to have one more question, I'm sure we could all have one question.

Mr. Chairperson: Well, we could continue until we run out of questions, right? I don't see too many more coming, so let's do that. We could spend most of the time talking about this. We could have all the questions dealt with, okay?

So, maybe we should deal with Mr. Nesbitt's question first? Mr. Nesbitt?

An Honourable Member: Don't we need a–sorry, Mr. Chair, just to interrupt. Don't we need a decision?

Mr. Chairperson: I thought we had agreement. *[interjection]* Oh, yes. Mr.–yes. Mr. Lindsey.

MLA Lindsey: So, if we could sit for another 10 minutes and that would give us time to clear up those questions.

Some Honourable Members: Agreed.

Mr. Chairperson: Okay. It's been agreed we're going to sit for another 10 minutes.

Mr. Nesbitt: I wanted to close with this question, but obviously I'm not going to.

Shared Health took over the operation of diagnostic services in 2017 after this report come out. I'm wondering if you can, in your opinion, tell us about the positive operational and organizational changes that have occurred since then.

Ms. Herd: What I've found is that with programs like this, in particular the diagnostic imaging program, in the past we had quite a wide range of divergence between Prairie Mountain, and how they operated the program out of Brandon, with Winnipeg and how they operated some of their services and with diagnostic imaging, and how they operated the services out of Boundary Trails and then Selkirk.

So the move to Shared Health does allow us to have more common practices and policies, especially in terms of wait-list management and central intake. It also is helpful–Shared Health, I think, through the pandemic, has been a great convener of all the major service-delivery organizations across the province. And so, within the pandemic we've seen some of the benefits of Shared Health having that power and ability to convene multiple clinical stakeholders in decision-making.

So, those have all been positive.

Mr. Chairperson: Mr. Lindsey, for your final question.

MLA Lindsey: No, I didn't have a final question.

Mr. Chairperson: Oh, you don't?

Mr. Michaleski, for your final question.

Mr. Michaleski: Yes, clearly there's lots of things that are changing with this MRI right now. We've got Shared Health in here, we've got clinical services plan, we have pandemic, we have labour shortages; so there's lots of things going on here.

My question is to the Auditor General: When can we expect, or can we expect, a follow-up report on the recommendations?

Mr. Shtykalo: So, this report we issued in 2017 and we've done our three years of follow-up, and that was our third and final follow-up. So there's nothing in the schedule to do any further follow-up. However, it doesn't mean we can't do a follow-up.

And there's different options that we could–ranging from going back in and doing a complete audit right from the–from top to bottom, right from the start again, to just doing a follow-up, getting responses and looking at the responses like we do in a traditional follow-up report.

Or now there's also options–the Public Accounts Committee could issue a request for a progress report at some time. And as is the process with that, we will–I will work with the Public Accounts Committee to look through the responses to the progress report and make a decision, kind of, where to go from there, whether it's to call the department back in to answer further questions, whether it's our office undertaking more procedures, et cetera.

So those are some of the options that would be in front of the Public Accounts Committee, but there's nothing right now scheduled, with respect to MRI services, from our office.

Mr. Chairperson: Okay. Well, hearing no further questions or comments, I'll now put the question on the reports.

Auditor General's Report titled Management of MRI Services, dated April 2017–pass.

Does the committee agree that we have completed consideration of Management of MRI Services of the Auditor General's Report, Follow-Up of Recommendations, dated March 2019? Agreed? *[Agreed]*

Does the committee agree that we have completed consideration of Management of MRI Services of the Auditor General's Report, Follow-Up of Recommendations, dated March 2020? Agreed? *[Agreed]*

Does the committee agree that we have completed consideration of Management of MRI Services of the Auditor General's Report, Follow-Up of Previously Issued Audit Recommendations, dated March 2021? Agreed? *[Agreed]*

The hour being 8:38, what is the will of the committee?

Some Honourable Members: Rise.

Mr. Chairperson: Committee rise.

COMMITTEE ROSE AT: *8:38 p.m.*