Equality, Dignity and Belonging

Building a Better System for People with Disabilities in Manitoba

Final Report of the Integrated Adult Services Pilot Project

An initiative started by
Amelia Hampton and Tyson Sylvester

June 2026

We acknowledge that the Integrated Adult Services Pilot Project, along with the drafting of this report, took place primarily on Treaty 1 Territory, and that community engagement occurred across various Treaty Territories, including Treaty 2 and Treaty 5.

We further acknowledge that Manitoba is located on the Treaty Territories and ancestral lands of the Anishinaabeg, Anishininewuk, Dakota Oyate, Denesuline and Nehethowuk nations.

We recognize Manitoba as the Homeland of the Red River Métis, and that northern Manitoba includes lands that have long been, and continue to be, the ancestral lands of Inuit peoples.

We honour the spirit and intent of Treaties and recognize the ongoing responsibilities they carry. We also acknowledge that public systems, including disability services, were developed within a broader colonial history that has harmed Indigenous Peoples, including Indigenous persons with disabilities.

With this acknowledgment, we affirm our continued commitment to work in respectful partnership with First Nations, Inuit and Métis people as we continue on a shared path of truth, reconciliation, and collective responsibility.

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Contents

*Due to the size of the Appendices, they can be downloaded separatetly from https://www.lockedoutoflife.com/

Forewords

Charlene and Keith Hampton, in Memory of Amelia Hampton

"She fought for change not only for herself, but for others whose lives do not fit neatly within rigid categories."

Our daughter, Amelia Savannah Hamel Hampton, was born on January 5, 1992, with a fighting spirit. She had a brilliant mind, a wicked sense of humour, and a determination that carried her farther than many people ever imagined. She lived with cerebral palsy and used a wheelchair. She didn't use words to communicate but had no trouble telling us what she wanted.

Amelia's vibrant spirit opened doors most would never expect. She was featured on a United Way billboard. She met Princess Anne through a horseback riding program. In 2010, she proudly carried the Olympic flame as a torchbearer. She loved animals deeply, especially her dog Mr. Bean. She lived a life marked by resilience, compassion, and advocacy.

When we first filed a complaint with the Manitoba Human Rights Commission, we did so as parents who could not accept that their daughter's future would be determined by an IQ score. Amelia required support with every aspect of daily living. Whether she scored above or below an arbitrary number would not change her physical vulnerability or her need for 24-hour care. Yet the Government treated that number as the gatekeeper to essential services.

Amelia was not asking for special treatment. She was asking to be seen fully — as a young woman with complex medical needs, physical dependence, intelligence, humour, and ambition. She fought for change not only for herself, but for others whose lives do not fit neatly within rigid categories.

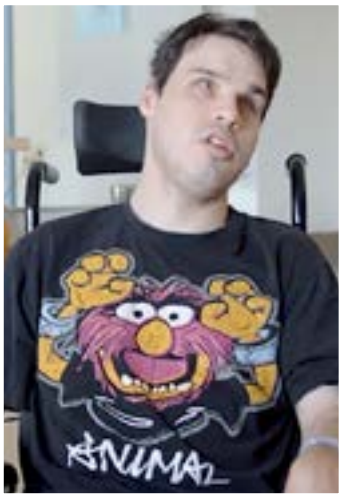
Amelia passed away suddenly in July 2024 at the age of 32. She did not live to see the final outcomes of this work. But her courage and her legal action helped spark this work aimed at improving services for people with complex medical needs. This report stands, in part, because she refused to accept a system that excluded her.

We miss her every day. We offer this introduction in her memory and in the hope that Manitoba will build a system where vulnerability is not reduced to a test score and where no family lives in fear of what will happen when they are no longer there to protect their child.

Charlene and Keith Hampton
Amelia Hampton's Parents

Tyson Sylvester

My name is Tyson Sylvester. I am a young adult in Manitoba. I am blind, I use a wheelchair, and I rely on others to move through my day and my community. I am also someone who had plans, to go to university, to study computer science, to build a life like anyone else my age.



"No one should be locked out of their life."

Before I turned 18, I had the supports I needed to do that. I went to school, spent time with friends, used technology to stay connected, and moved through my community. I was living my life.

Then I became an adult, and the system took that life away.

My needs did not change. The system did.

The supports that allowed me to leave my home, connect with others, and plan my future were replaced with a model that focuses on basic survival. I lost access to the tools I relied on, including the screen reader I needed to use a computer. I lost the support to go out into the world. What I was left with was a capped number of hours for things like eating, dressing, and hygiene.

That is not support for living. That is maintenance.

There are 168 hours in a week. When support only covers a fraction of that time, what you are really being told is that the rest of your life does not matter.

Without the right supports, I became isolated. My world was reduced to my home. Eventually, I was moved into a personal care home with seniors, not because it was appropriate, but because there were no other options.

That is not care. That is containment.

I was not asking for anything extra. I was asking to continue the life I had already been living.

Through the Locked Out of Life campaign, I made that reality visible. I sat in a jail cell in downtown Winnipeg so people could see what the system was doing. The truth is, I was already in a different kind of cell, one built by policies that decide who gets to participate in life and who does not.

This is not an isolated case. It is a predictable outcome of how the system is designed. Young adults with physical disabilities lose supports at the exact moment they are ready to move forward. Turning 18 becomes a cutoff, not a transition.

This report cannot just describe that problem. It needs to change it.

A system that only supports survival is not enough. A system that places young people in environments that do not fit their lives is not working. A system that takes away opportunity at adulthood is failing.

We can do better than this.

No one should be locked out of their life.

Tyson Sylvester
Disability Advocate

Message from David Kron

Chair of the Integrated Adult Services (IAS) Steering Committee

As Chair of the Integrated Adult Services Pilot Project ("IAS pilot") Steering Committee, I would like to extend a sincere thanks to my fellow steering committee members, with deep thanks to Amelia, Charlene & Keith Hampton, Tyson Sylvester, Leanne Fenez, Lindsey Cooke, Alex Lytwyn, Taja Lonstrup, Sandy McLennan, Karen Sharma, Laurel Litardi, Jennifer Harwood, Alanna Hager, Fiona Jeffries, Ibikunle Adeakin, and Piaroa Nunez.

I would also want to thank Manitobans who came out and shared their stories and experiences in the public engagement. The hours of dedication, advocacy, and hard work you have contributed is deeply appreciated. Your expertise has been vital to guiding the IAS pilot.

Thank you to everyone who participated in the pilot project. Your contribution and participation informed meaningful systemic change in the province. Everyone involved in the IAS pilot is joined by a mutual dedication to creating a better Manitoba for adult with disabilities.

The IAS pilot final report is a significant milestone that highlights how important reform of adult disability services is. Our province is siloed in services and jurisdiction, and the complex system individuals, families, and service providers have to navigate creates insurmountable barriers that prevent people from getting the support they need. The system is unnecessarily complicated. When support and access to services is based on diagnosis, geography or timing instead of need, people often must use all their energy to get services. Every step forward requires countless hours of advocacy, highlighting how invaluable this pilot project is and how much more work remains.

The IAS pilot was based on human rights complaints filed in 2016. What started as complaints about discrimination and inadequate supports for two people, became a decade-long effort for improved services for all. Tyson Sylvester and Amelia Hampton refused to accept anything less than systemic change, and as this pilot project comes to an end, it is systemic change we need.

As we look forward to the future, it is our hope that the findings and recommendations of this pilot project inform and inspire real change. The work put into this initiative over the last decade cannot end here.

Thank you to all for your energy, dedication and hard work.

About this Report - Easy Read Summary

This is a summary of a big report that uses plain and simple words. You do not need to read the full report to understand this summary.

How to Use This Summary

This summary tells you what the report is about.

Each section has a picture on the left.

The picture helps explain the words on the right.

You can ask someone to help you read it.

Who Started This and Why

Two people named Tyson Sylvester and Amelia Hampton started this.

Tyson is blind and uses a wheelchair.

Amelia had cerebral palsy and needed support every day.

When they turned 18, they lost many of the supports they needed.

Their needs did not change. But the system changed how it helped them and it was not enough for them.

Tyson and Amelia made a human rights complaint against the Manitoba government.

A human rights complaint means saying: the government treated us unfairly.

An investigation found that they believed that the government had treated them unfairly.

The government agreed to try a new way of helping people to see if it worked.

What Is Wrong With the System

Right now, many people with disabilities cannot get the help they need.

The rules say you must have a certain kind of disability to get some kinds of help.

Different services are run by different government departments. They sometimes do not talk to each other.

Most services are only in Winnipeg. People in small towns have very few options.

People fall through the cracks. They go without help. Their health gets worse.

Families and caregivers have to help when government does not. Many are exhausted and burned out.

What Was the Integrated Adult Services Pilot Project?

The government agreed to test a new way of helping people. They started the Integrated Adult Services pilot project.

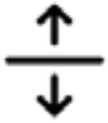
The project ran from April 2023 to September 2025.

It supported 33 adults who needed a lot of help.

All people who were part of the pilot lived in the Winnipeg area.

A small team of two workers supported the people in the pilot.

Each worker only had about 15 people to support at one time.



In the regular system, one worker might support 100 or more people.

The workers took time to really listen. They asked: what do YOU need?

They worked across different government departments at the same time.

A Steering Committee helped guide the project. It included people with disabilities, families, service providers, and government.

Chalet Point Consulting did an independent evaluation of the pilot project. That means they checked if it was working and talked to people about their experiences.

The St.Amant Research Centre (SARC) helped with research. They looked at how other places support people with disabilities and shared what they found.

What Did the Project Show?

Most participants said their lives improved.

20 people got more hours of home care support.

14 people got support to do more things in the community, like grocery shopping or going out.

Workers helped people get equipment, see doctors, find housing, and get other supports.

People said they felt safer, less lonely, and more in control of their own lives.

Family caregivers had less stress when formal supports were in place.

The project also showed that some problems could not be fixed by workers alone.

There was not enough accessible housing. There was not enough money to try new things. Some rules could not be changed.

To help everyone, the whole system needs to change, not just how workers do their jobs.

What People in Manitoba Told Us

210 people across Manitoba shared their experiences with Chalet Point Consulting.

They came from Winnipeg, Brandon, Thompson, Dauphin, Steinbach, and other communities.

They all said similar things:

Income supports do not cover the real cost of living with a disability.

There is not enough safe and accessible housing.

People in small towns and the North have very few services nearby.

When young people turn 18, they often lose important supports.

Mental health support is very hard to access.

Finding out how to get help through the system is confusing and exhausting.

What We Are Asking the Government to Do

The most important recommendation is that the government must build a new disability support system. This system must follow human rights law.

Here is what the new system should do:

Let more people in. Stop turning people away because of test scores or the wrong kind of diagnosis.

Make sure people do not lose supports when they turn 18, 21 or 65.

Create one place where people can get help. Stop making people deal with 5 different departments.

Give people enough money to live with dignity. Let them choose how to use their supports.

Create more accessible housing. Stop putting people in nursing homes when that is not the right fit.

Hire and train more disability support workers. Support family caregivers too.

Make mental health support available to people with complex disabilities.

Make it easier and faster to get equipment. Do not take it away at age 18.

Make sure people can get to services, including in small towns.

Remove barriers for First Nations people. They must have equal access to supports everywhere.

Make sure people in rural and northern communities get real services, not just promises.

Create an independent disability advocate. Have someone check that the government is doing what it promised.

What Happens Next?

The Manitoba government made a promise to do their best to act on these recommendations.

That promise came from a human rights process. It must be kept.

People with disabilities, families, and communities should help shape the new system.

There should be a clear plan to make changes, with clear timelines.

Executive Summary

Context

The Integrated Adult Services (IAS) pilot project emerged from a human rights process. In 2016, Amelia Hampton and Tyson Sylvester each filed a complaint under The Human Rights Code with the Manitoba Human Rights Commission (MHRC) against the Manitoba government and the Winnipeg Regional Health Authority (WRHA). Their complaints alleged systemic barriers in Manitoba's disability services system.

Amelia and Tyson's complaints alleged that Manitoba's current disability services system was inadequate and failed to meet the needs of adults with complex disabilities. Their cases highlighted that when young people with complex disabilities "age out" of children's services, they can lose essential supports even though their needs have not changed. The complaints pointed out gaps and barriers in the provision of services and how these impacted their physical and mental health.

The MHRC determined there was sufficient evidence that the Manitoba government and the WRHA had discriminated against the complainants and other adults with disabilities to justify the matters moving to a public hearing before the Manitoba Human Rights Adjudication Panel. Prior to the adjudication, the parties agreed to participate in a mediation process to attempt to resolve the complaints without the need for a formal hearing. Through mediation, the Manitoba government and WRHA committed to developing a pilot project designed to test a new model of service delivery for adults with complex disabilities and to making best efforts to implement recommendations stemming from the pilot project. The terms of the IAS pilot were set out in a settlement agreement.

The IAS pilot ran from April 2023 to September 2025. It supported 33 adults with both a medical diagnosis and complex disability-related needs, living in the Winnipeg Health Region. Pilot participants were selected from applicants who met certain criteria, with consideration given to ensure broader representation and diversity.

The model was built with a team composed of one case coordinator from WRHA Home Care and one case manager from Manitoba Families ("IAS team"). Each IAS coordinator carried a caseload of approximately 15 participants, compared to approximately 100 to 135 in standard provincial programs. The IAS team:

- Used open-ended "discovery meetings" rather than standardized intake tools to understand each person's goals, supports, and barriers in their own words.
- Provided intensive case coordination and navigation across systems, sought "creative solutions" within existing systems, and escalated requests to senior leadership when participants' needs could not be met within current guidelines.

The pilot was overseen by the IAS Steering Committee, which included government representatives, people with lived experience of disability, family members, community members (including representatives from outside the City of Winnipeg), service providers, and a representative from the MHRC. Amelia Hampton and Tyson Sylvester were members of the Steering Committee. Following Amelia's sudden passing in July 2024, her mother continued to participate on the Steering Committee.

Independent evaluation of the IAS pilot was conducted by Chalet Point Consulting, which assessed quality of life outcomes for IAS participants and conducted province-wide community engagement. The St.Amant Research Centre (SARC) provided academic research and jurisdictional scans on topics including eligibility models, self-directed care, equipment access, housing, and income supports as directed by the Steering Committee.

From the outset and throughout the IAS pilot, community representatives and government representatives on the Steering Committee held differing understandings of the pilot's intended purpose.

Community members understood it as an opportunity to test new approaches, practices, and service arrangements that could generate evidence about what works — with the expectation that creative solutions would inform policy change and system reform. In their view, escalating decisions to senior government authority meant seeking authorization to trial new approaches that could challenge existing policies and practices.

Government representatives understood the pilot as an opportunity to test person-centred workarounds for pilot participants within the parameters of the current system and budget, led by the IAS team. It often included making participant-specific exceptions to existing policies to allow participants to receive more services. For government representatives, escalation was a case-by-case administrative step for approvals that fell outside standard policy and/or funding guidelines.

This difference of interpretation influenced the implementation of the pilot. Community representatives raised concerns that creative solutions were being applied as exceptions rather than tested as scalable approaches, and that available information on participant needs and solutions was too high-level to support meaningful input. Government representatives attributed these limitations to privacy requirements under The Freedom of Information and Protection of Privacy Act (FIPPA) and The Personal Health Information Act (PHIA).

Pilot Participant Outcomes

As reflected in the Chalet Point report summary and the Creative Solutions section, the IAS pilot showed that when supports are coordinated, flexible, and person-centred, people's lives improve in tangible ways. With a caseload of 30 participants, the IAS team was able to secure increased WRHA Home Care hours for 20 people and weekly supported independent living hours for 14, and to help participants access equipment, counselling, medical appointments, employment supports, housing options, and other supports that they could not have obtained on their own.

Chalet Point's outcome evaluation found that most pilot participants experienced meaningful improvements in quality of life, independence, mental health, and relationships when supports were organized around their goals.

Examples of positive outcomes for IAS participants include:

- Safer and more stable living arrangements.
- Improved ability to remain in or return to community from hospital, and better access to essential equipment and home supports.
- Increased autonomy in daily routines, reduced isolation through support for community outings and social participation.
- Stronger, more sustainable relationships with family caregivers when formal supports reduced burnout.
- Additional home care hours, help organizing medical care, or navigation assistance with income and equipment programs, made the difference between barely surviving and beginning to build a life.

These outcomes were achieved without creating entirely new programs. They arose from delivering existing services differently, through intensive, person-centred coordination, flexible use of supports across program lines, and a deliberate focus on functional needs rather than diagnostic labels alone. This demonstrates that service delivery methods matter and that system architecture can either enable or block good practice.

At the same time, a small number of participants reported limited changes because the barriers they faced were fundamentally structural, such as lack of accessible housing, inadequate income, or policy restrictions, emphasizing that navigation alone cannot fix current system barriers.

Systemic Gaps and Challenges

Across the Creative Solutions section, as well as the Chalet Point and SARC report summaries, the report identifies various systemic gaps observed through participant experiences, community engagement and academic research.

SARC's research and jurisdictional scan work showed that Manitoba's challenges within the disability supports system were similar to broader patterns across Canada, including rigid and medically-oriented eligibility criteria, inadequate income supports, fragmented equipment and housing programs, and limited outcome evaluation. Their review identified promising practices in other jurisdictions, including needs-based eligibility frameworks, individualized and flexible funding models, strengthened accessible housing policies, and multi-pronged supports for family caregivers. Their review also noted significant evidence gaps and implementation challenges for existing programs throughout Canada.

Chalet Point's community engagement with 210 Manitobans detailed how people with disabilities experience inadequate income supports, insufficient and inflexible home care, lack of accessible and dignified housing, travel burdens and service gaps in rural and northern communities, and workforce shortages and instability in the disability sector.

The Creative Solutions section of this report documents both the practical, person-centred solutions the IAS team implemented and the challenges they found when policies and funding limits did not allow for broader changes.

Consistent and systemic challenges emerged across all the input sources including the (1) IAS Team's direct experience documented within the Creative Solutions section of the report (2) the Chalet Point Evaluation and Engagement, and (3) SARC's research and jurisdictional scan. These were raised in relation to:

- **Eligibility criteria and transitions:** IQ-based criteria and diagnosis specific programs, such as Community Living disABILITY Services (CLDS), exclude many adults with significant functional needs. People are "not disabled enough" for one program, "the wrong disability" for another, or lose supports at 18, 21 or 65 despite unchanged needs.
- **Income supports:** Employment and Income Assistance (EIA) and Manitoba Supports for Persons with Disabilities (MSPD) are the two provincial programs that provide financial assistance to people with disabilities. Across community engagement, lack of flexibility and insufficiency were listed as major challenges. SARC's research showed that this is a reality across Canada.
- **Housing:** People with disabilities have the right to live independently and to be included in the community, which means they need to have access to accessible and affordable housing. Lack of available housing was brought up consistently in engagement sessions and by IAS participants.
- **Mental health supports:** Community engagement participants expressed the difficulties of accessing mental health supports when an individual has co-occurring mental health and disability-related needs. Mental health was one of the most significant concerns among IAS and they often requested help navigating and accessing these services.
- **Home care services:** Home care hours are restricted to activities performed inside a person's home, generally limited to predetermined hours, and subject to rules that create challenges for many individuals, as indicated by community engagement and IAS participants. These parameters may not fully align with broader needs related to community participation and daily living.

- **Service structures:** Across the disability supports system, people experience services as fragmented and exhausting to navigate, dealing with separate income support, home care, equipment, housing, and mental health systems that do not align and may contradict one another. Further, engagement and pilot participants expressed that administrative processes make coordination complex and difficult to manage.

It should be noted that community engagement showed that these challenges are even greater in rural and remote communities, where the resources to deliver services may be limited and the distances to travel to needed services are significant. System challenges are also felt more acutely by Indigenous communities across Manitoba.

Summary of Recommendations

The IAS pilot, the community engagement and evaluation conducted by Chalet Point Consulting, and the academic research conducted by SARC inform a comprehensive set of recommendations for disability support system reform in Manitoba.

These recommendations are organized around a core principle: **Manitoba must establish a new disability support system that is grounded in human rights law and principles, and that serves people based on what they need, not on diagnostic labels, program silos, or arbitrary geographic or age boundaries.**

1. Core Recommendation - Establish a New Disability Support System in Manitoba
Manitoba must create a province-wide disability support system fully compliant with human rights law, grounded in the Human Rights Code, the Canadian Charter of Rights and Freedoms, and the UN Convention on the Rights of Persons with Disabilities. The system must be designed, governed, and held accountable through the leadership and lived expertise of people with disabilities, families, and communities. There must be no exceptions, including for First Nations people living on or off reserve.

Replace Diagnosis-Based Eligibility with Needs-Based Eligibility
Manitoba should immediately suspend the use of IQ-based eligibility thresholds within CLDS and replace diagnosis-driven criteria system-wide with a functional, needs-based eligibility framework that focuses on the supports a person requires to live safely, independently, and with dignity. Diagnostic exclusions — for people with ABI, autism, FASD, mental health-related disabilities, and others — should be eliminated. A single eligibility determination process, co-designed with people with lived experience, should be recognized across all disability-related programs.

2. Ensure Continuity of Supports Across the Lifespan
The transition from children to adult disability services should be supported, planned, and funded. No person should lose access to supports simply because they turned 18. Continuity of supports should be guaranteed across the lifespan as needs, goals, and circumstances change.

3. One-Door Navigation and Cross-Department Coordination
Manitoba should establish a single, accessible point of entry for disability supports, a one-door navigation model, with coordinated case management that spans Manitoba Families and WRHA. Fragmentation between departments and programs should be addressed structurally, not managed through individual workarounds.

4. Reform Income and Funding
Income supports should be adequate, flexible, and reflective of the real costs of living with a disability. Manitoba should develop individualized, person-controlled, portable funding models that allow people to direct their own supports — including for community participation and daily life management, not only personal care tasks.

5. Expand Accessible and Dignified Housing Options
Manitoba should invest in accessible, community-based housing options for adults with disabilities. This should include a dedicated home modification program for working-age adults, support for people to remain in their own homes, and an end to the practice of placing people in personal care homes by default.

6. Support the Disability Workforce and Family Caregivers
Manitoba should address critical shortages in the disability support workforce, including consistent and trained home care workers. Family caregivers who are filling gaps in formal services deserve recognition, respite, and support, including the ability to hire family members as paid workers when no one else is available.

7. Ensure Equitable Access to Health and Mental Health Care
Mental health supports should be accessible to people with complex disabilities. The current capacity limits and high-priority thresholds that exclude this population must be addressed through coordinated policy between departments.

8. Improve Access to Equipment
Equipment access should be timely, clinically driven, and managed through a clear, single point of accountability. Equipment that is covered for children should not simply disappear at age 18.

9. Provide Accessible and Adequate Transportation
Transportation policy should support community participation. Home care hours must be usable in community settings, not only within a person's home. Accessible transportation options should be available in rural communities, not only in Winnipeg.

10. Uphold Indigenous Rights and Partnership
Manitoba should eliminate policy exclusions that restrict access to services for First Nations people. Indigenous people with disabilities should have equitable access to all disability supports, on-reserve and off-reserve, without jurisdictional barriers or delays. Indigenous communities and leaders should be genuine partners in the design and governance of the new system.

11. Address Rural and Northern Equity
Services should be accessible where people live. This includes accessible service delivery in rural, remote, and northern communities; regional representation in provincial funding discussions; and investment in local service capacity outside of Winnipeg.

12. Establish Governance, Accountability, and Independent Oversight
Manitoba should establish a provincially funded, independent disability advocate, modelled on the Manitoba Advocate for Children and Youth. Implementation of the new system should be monitored by an independent body. A transparent five-year implementation plan, with measurable outcomes and public reporting, should be developed and resourced.

13. Commit to Ongoing Evaluation and Improvement
The new system should be built on a foundation of evidence, continuous learning, and accountability to outcomes, not only outputs. Evaluation should involve people with lived experience of disability and be designed to measure what matters in people's lives.

Conclusion

The IAS pilot emerged from two human rights complaints that identified alleged systemic discrimination within Manitoba's disability supports system. The pilot represented an effort to test a new model of service delivery and examine how services for adults with complex disability-related needs can be improved within Manitoba.

Through its implementation, the pilot demonstrated that coordinated, flexible, and person-centred services can improve access to services and contribute to positive outcomes. These findings are consistent across participant experiences collected through independent evaluation.

At the same time, community engagement, participant outcome evaluation and research related to the pilot emphasized the ongoing challenges within the existing system. These include barriers related to eligibility criteria, program fragmentation, funding limits and gaps in areas such as housing, transportation, access to equipment and clinical supports.

The recommendations in this report outline a potential path to change Manitoba's approach to the disability support system to one that upholds human rights and supports good lives for all adults with disabilities in Manitoba.

Manitoba Families, Manitoba Health, Seniors and Long-Term Care and the WRHA committed to consider the recommendations that flow from the IAS pilot and make best efforts to implement them. The IAS Project Charter establishes a six-month period following the release of this report for government to review and respond to the recommendations and present a go-forward plan.

The government response to the IAS pilot recommendations will guide how the disability supports system will continue to evolve and improve, moving toward a future where all Manitobans with disabilities have access to services and supports they need to live in equality, dignity and respect.

Overview of the IAS Pilot Project

History of IAS Pilot

In 2016, Amelia Hampton and Tyson Sylvester each filed a complaint under The Human Rights Code with the Manitoba Human Rights Commission (MHRC) against the Manitoba government (Manitoba Families and Manitoba Health, Seniors and Active Living)[1] and the Winnipeg Regional Health Authority (WRHA). They alleged that gaps in the provision of adequate services to adults with disabilities, particularly those with complex disability-related needs, result in systemic barriers to equality.

Hampton and Sylvester's complaints highlighted the significant barriers that individuals with complex disabilities may face in accessing disability services in Manitoba. These barriers are experienced most acutely after transitioning from children's disability services to adult supports, including:

- **Inadequate Services**: Following transition from children's services, some adults with disabilities lose access to services that support daily living, even though their need for support services has not changed. The complaints allege that these gaps in services are, in part, the result of discriminatory eligibility criteria that limit access to services and supports. Some of the gaps in supports include:
    - Personal care
    - Home care
    - Respite services
    - Clinical supports (e.g., OT, PT, SLP, mental health supports)
    - Equipment and supplies
    - Housing, education, employment, and day programs

1 Manitoba Health, Seniors and Long-Term Care.

- **Barriers to Equity and Dignity:** Gaps in services result in significant barriers to equity and impact the autonomy and dignity of persons with disabilities.
- **Fragmented and Uncoordinated Services:** Adults with complex disabilities lack access to clear information, assistance and navigation support.

The complaints were investigated under Manitoba's Human Rights Code. The purpose of the investigations was to determine if there is sufficient evidence to require a public hearing of the complaints before Manitoba's human rights tribunal.

The Investigator's reports found sufficient evidence that Manitoba discriminated against the Complainants and other adult Manitobans with disabilities, and that this discrimination was not reasonable. In particular, the investigator reported that:

The transition from children's to adult disability services ("aging out") lacks system support, resulting in service access gaps or disruptions in continuity of care.
Adult services do not enable the full participation of adults with disabilities.

Following the investigation, the MHRC referred the complaints to Manitoba's human rights tribunal for a hearing. Before proceeding to hearing, Sylvester, Hampton, the Manitoba government, the WRHA and the MHRC agreed to take part in a mediation process to work through the complaints.

This process led to an agreement in which the Manitoba government and the WRHA acknowledged there are differences in the provision of services and supports to some Manitobans with disabilities, especially those with complex disability-related needs.

In recognition of these systemic differences, the Manitoba government and the WRHA committed to develop a pilot project to test a new model of service delivery for adults in Manitoba who have both a medical diagnosis and complex disability-related needs.

The Integrated Adult Services (IAS) pilot project emerged from this commitment. As a new model of service delivery for adults with disabilities, focused on person-centred planning, improved navigation, and coordinated care, the IAS pilot project was to be guided by the following principles:

- The IAS model would be person-centred;
- Assessment and service delivery would be based on each individual's needs;
- The model would emphasize service coordination and navigation;
- Creative solutions and problem solving within the parameters of existing systems would be emphasized;
- The IAS Team would identify gaps, limitations, resource needs or system barriers that may exist;
- The model would be rooted in research, evidence and best practice; and
- Evaluation of programming and services would be based on actual outcomes.

Community engagement was part of the implementation of the IAS pilot. Through an accessible engagement process, the pilot engaged with and documented the lived experience of adults with a medical diagnosis and complex disability-related needs living throughout Manitoba, while addressing gaps in supports and service for 30 eligible adults in the Winnipeg Health Region.[2]

As part of the agreement reached by the parties, the Manitoba government and the WRHA agreed to make their best efforts to implement recommendations flowing from the IAS pilot.

IAS Pilot Service Design

This service delivery model was based on an intensive case management framework and delivered by a collaborative team composed of staff from Manitoba Families and WRHA. The caseload was intentionally set at a lower number compared to the average caseloads within provincial disability programs.

Per the agreement, the IAS team would support a reduced caseload of up to 30 adults and was responsible for:

- Assessing functional needs for each participant using a person-centred discovery approach.
- Coordinating, navigating and managing services for IAS participants.
- Leveraging services and supports across their respective systems and external services, partners and programs.
- Providing further comprehensive assessments and/or case management supports as needed, and offering IAS participants the option to self-manage their supports.
- Identifying creative solutions within existing mandates and policies when individuals did not meet certain eligibility criteria but still required supports.
- Seeking authority from Manitoba Health, Seniors and Long-Term Care and Manitoba Families as required.
- Reporting barriers and gaps in programming and systems to the Steering Committee.

To carry out these tasks effectively, the team was staffed by two dedicated case coordinators: one from WRHA Home Care nursing and one from Manitoba Families. The IAS model was supported by a joint management framework, with one manager from Manitoba Families and from the WRHA, to guide implementation of the model.

The IAS team was to be supported and overseen by key stakeholders and partners throughout the pilot project. This included a Steering Committee, which collaborated closely with an independent evaluator and an academic expert to ensure the integrity and effectiveness of the model.

2 Winnipeg Health Region serves residents of the City of Winnipeg, as well as the northern community of Churchill and the rural municipalities of East and West St. Paul.

Key Stakeholders and Partners

1. IAS Steering Committee

In the agreement, the parties established that a Steering Committee would be appointed to provide development, oversight and direction for the IAS pilot. The Committee would be comprised of individuals with a variety of areas of expertise including:

- A leadership team from each system (departments of Families, Health and the Winnipeg Regional Health Authority)
- Experts from each system
- Tyson Sylvester and Amelia Hampton
- Community members including a representative from outside The City of Winnipeg
- Family members
- Service providers
- A representative from the Manitoba Human Rights Commission

The parties recognized the importance of lived experience and committed to ensuring that at least one third of the Steering Committee would be comprised of persons with lived experience.

The agreement defined that, once established, the Steering Committee would choose an independent evaluator to conduct community engagement, guide the interim and final reports, and make recommendations to government leadership.

Invitations to join the Steering Committee were issued in August 2021, and the Committee held its first meeting on October 21, 2021.

In September 2022, the Steering Committee finalized its Terms of Reference, with approval from the Manitoba government and the WRHA. Guided by the principles of the settlement agreement, the Steering Committee defined its purpose and mandate, as well as the responsibilities of members and the Chair. The Steering Committee designated David Kron, Executive Director of the Cerebral Palsy Association of Manitoba, as the Chair.

As outlined in the Terms of Reference, the purpose of the Steering Committee was to provide independent expertise, direction and oversight of the development and implementation of the pilot project, and to ensure that it is conducted in a manner reflective of best practice and community input. The Terms of Reference and the Project Charter are provided in Appendices A and B, respectively.

The mandate of the Steering Committee was to direct and oversee the development and implementation of IAS, which included an active role in:

- Participant selection
- Individualized assessments
- Coordination of supports
- Engagement of academic and evaluation experts
- Submission of interim and final reports

Members of the Steering Committee were responsible for holding a minimum of one meeting per month and participating in monthly meetings and carrying out tasks accordingly. The Chair had the responsibility of developing the meeting agendas, leading and encouraging members to participate in discussions and decision-making, and keeping track of meeting records.

2. Independent Evaluator: Chalet Point Consulting

As established in the settlement agreement, IAS was to employ an independent evaluator, subject to available funding, to evaluate the pilot project and assist with ongoing recommendations, as well as both interim and final reporting. In May 2023, Manitoba Families entered into a service agreement with Chalet Point Consulting for the independent evaluator role.

Chalet Point conducted an evaluation process focused on individual participant outcomes, system learning, and engagement with those with lived experience to inform potential systemic change. The independent evaluator was tasked to produce the following:

- An interim report with recommendations based on preliminary results from the process evaluation and community engagement sessions data.
- A community engagement report with a summary of the two rounds of engagement.
- A final report with the results of the participant outcomes evaluation, community engagement analysis and recommendations. This report is included as Appendix C.

3. Academic Expert: St.Amant Research Centre

The settlement agreement also identified that the pilot would engage an independent researcher, subject to available funding. With the purpose of assisting the Steering Committee with its work, the Manitoba government entered into an agreement with St.Amant Research Centre (SARC) to provide academic research services for the IAS pilot. This included review of existing literature and research, jurisdictional scans, summary of research reviewed and presentations to the Steering Committee to inform the recommendations.

SARC acted as a resource to the Steering Committee, and supported IAS by:

- Presenting their literature review and research findings to the Steering Committee.
- Summarizing and presenting findings to the committee and supporting the pilot's evidence-based approach.
- Ensuring the project remained grounded in current research and best practices.

In January 2026, SARC submitted a two-part summary report with their findings, which is included as Appendix D.

Selection and Assessment of IAS Pilot Participants

The Manitoba government launched a call for applications in collaboration with the IAS Steering Committee. Various community organizations supported participant recruitment efforts through surveys, posters, emails, and community social media engagement, from November to December 2022.

Interested individuals were invited to submit an application form (online, phone or paper format). Selected applicants had to meet the following criteria based on a predetermined geographic and demographic scope:

- Live in the Winnipeg Health Region (includes Winnipeg, Churchill and East and West St. Paul).
- Be age 18 or older.
- Have a medical diagnosis and a permanent complex physical disability or a permanent complex physical and intellectual disability.
- Have experienced challenges accessing disability related supports and services in Manitoba.

The IAS application form received a total of 84 submissions. In line with the settlement agreement, the IAS participant group would represent a diverse range of needs, ages, genders, and cultural backgrounds. Demographic diversity was a key priority, with intentional recruitment to ensure representation across age groups while ensuring Indigenous representation and gender diversity.

The selection subcommittee did not define "complex" as related to disability with intention to provide flexibility in how applicants were experiencing disability. The subcommittee selected one resident of Churchill to attempt to test pilot with a remote resident.

The selection process was discussed with personnel from SARC. The process was also supported by a graduate student within Manitoba Families who reviewed submissions to ensure alignment with the project's focus.

In January 2023, 28 applicants were selected to participate in the IAS pilot, along with Amelia Hampton and Tyson Sylvester. This was done by mix of targeted diversity and random selection. As people left the pilot, new people were selected to maintain pilot of 30 participants. The total number of participants was 33.[3]

3 The pilot was set for a caseload of 30 individuals. The total number of participants was 33 due to additional intake under specific circumstances.

Discovery Meetings

IAS participants' needs were assessed in line with the pilot project's goal of tailoring service delivery to each individual. This process began with an initial meeting between participants and IAS case coordinators, known as discovery meetings. These meetings took a more personalized approach to needs assessment, focused on making the participant comfortable, rather than conducting a formal assessment or intake process based on their medical history. This approach ensured that service plans were person-centred and collaborative.

Rather than following a prescribed agenda, discovery meetings were open ended and lasted for as long or as little as the participant wanted. IAS coordinators allowed individuals to share their lived experiences and expectations across key areas, including:

- Current service involvement
- Current and past challenges
- Preferred frequency of meetings (e.g., quarterly, biannually)
- Personal goals for the pilot project

The IAS team identified varying levels of needs and required supports among the participants. These needs differed significantly from person to person and included, but were not limited to:

- Access to new equipment, modifications and repairs
- Therapy services (e.g., physiotherapy)
- Home modifications
- New housing or residential placement
- Assistance with hospital discharge process
- Community-based care hours and supports
- Assistance with medical appointments, health care support and advocacy
- Mental health services
- Transportation
- Desire for proactive services
- Services that provide appropriate support for (younger) adults

Closing Summary

The Manitoba government (Manitoba Families and Manitoba Health, Seniors and Long-Term Care) proposed the IAS pilot as a public interest remedy emerging from a human rights complaint process with the Manitoba Human Rights Commission. The purpose of this pilot was to test a new model of service delivery for adults with a medical diagnosis and complex disability-related needs.

The IAS team, whose role was to deliver intensive case management and identify creative solutions to support IAS participants in accessing services, was central to this new model. The modest caseload of 30 participants set by the pilot and the approach given to discovery meetings enabled the team to provide intensive case management and coordinate person-centred planning.

The IAS Steering Committee provided oversight and direction for the IAS pilot, functioning as an integral body that included government representatives from Manitoba Families and WRHA, community members and individuals with lived experience.

With input from Manitoba Families and WRHA, as well as guidance from the IAS Steering Committee, the IAS team navigated the disability services system and trialed creative solutions to coordinate services for participants. The team also encountered challenges throughout the pilot, which reflected system barriers shaped by policies and program structures. The creative solutions process and systemic barriers revealed throughout the pilot will be explored in the following section.

Creative Solutions Trialed in the IAS Pilot

Scope and Expectations

The agreement that created the Integrated Adult Services (IAS) pilot included two provisions related to creative solutions:

> Under paragraph 7, which outlines IAS principles,
>
> "**Creative solutions** and problem solving **within the parameters of the existing systems** will be emphasized."
>
> Under paragraph 15, which addresses eligibility,
>
> "The provision of certain services may require that individuals meet eligibility criteria. In situations where an individual does not meet eligibility requirements but requires the supports, **the IAS team will either find a creative solution within current mandates and policies or seek authority** from Manitoba Health and Seniors Care [now Manitoba Health, Seniors and Long-Term Care] and Manitoba Families as required."

From the start of the pilot, the scope of "creative" solutions was interpreted differently by Steering Committee government representatives and community representatives. These differing views influenced how creativity was practiced throughout the pilot and ultimately led to different outcome expectations:

- Community representatives interpreted creative solutions to include testing new approaches, practices and service arrangements within the pilot that could help address known barriers for pilot participants and generate evidence about what works in practice to inform future systemic reform. Escalation to higher authority was interpreted as seeking authorization to trial solutions that could inform future policy changes.
- Government representatives interpreted this process as trialing person-centred workarounds for pilot participants within the parameters of the current system and budget, led by the IAS team. Escalation to higher authority was viewed as a case-by-case step for specific creative solution requests and was used when services required approval outside standard policies and/or practices.

This section reviews the implementation of creative solutions and how these differing understandings influenced the direction, opportunities and limitations of the pilot. It also acknowledges the IAS team's efforts in navigating supports and services for the participants, the work of the IAS Steering Committee community representatives, and the barriers and gaps identified throughout the pilot.

IAS Team and Person-centred Approach

The IAS team, staffed by one Winnipeg Regional Health Authority (WRHA) nurse case coordinator and one case coordinator from Manitoba Families, was expected to take a proactive person-centred and problem-solving approach to case management. The IAS team staff will be referred to as "IAS coordinators" or "IAS team" throughout.

With a caseload of 30 participants, the IAS team was able to provide intensive case coordination and individualized support that is not typically available in standard practice. Each IAS coordinator supported 15 participants, which is significantly lower than average caseloads in Manitoba government disability and health programs. For instance:

- A typical caseload per one Community Living disABILITY Services (CLDS)/Children's disABILITY Services (CDS) case worker is approximately 110 to 135 participants with needs ranging in complexity.
- Within Integrated Children's Services (ICS), case workers typically support a combined caseload of ICS and Unified Family Support cases, with a target of 75-80 each.
- Full-time WRHA Home Care positions typically support a combined caseload of approximately 100 participants each, based on current staffing and case distribution.

The IAS team's person-centred approach to case coordination involved finding creative solutions within existing systems and seeking higher-level authorization to approve services and supports when needed. IAS coordinators emphasized navigating and leveraging available service structures

and resources. They also explored and offered service options in response to the needs identified through discovery meetings and participants' requests on a case-by-case basis. While each case was unique, the IAS team worked through a similar 3-step process, as outlined below:

1. Service requests and options: Based on assessed and self-described needs and goals, the IAS team would suggest supports and services, which participants could accept or decline. Participants could also request specific services if they were aware of available options.
    - Services proposed by IAS coordinators were not mandatory for participants. At times, participants opted out after initially agreeing to certain supports.

2. System navigation: The IAS team explored options across systems to identify appropriate supports within current program and service policies.
    - The IAS team was able to approve certain services immediately under department service and funding guidelines (particularly, within Manitoba Families' Community Living disABILITY Services and WRHA Home Care programs).
    - For services beyond department guidelines, the IAS team would consult with assigned managers from Manitoba Families and WRHA at weekly meetings and decided the most suitable course of action.
    - If necessary, requests or proposed solutions were escalated to senior leadership for approval. This was required, for example, in cases where funding requests were above guidelines or constituted exceptions to policies.
    - The timelines for assessment and approval of service requests varied depending on complexity, typically ranging from one day to two weeks.

3. Access determination: Based on the results of service navigation and approval processes, services or supports were either offered or not provided.
    - Immediate access was granted by the IAS team when requests fell within guidelines.
    - Requests outside departments' policies and guidelines that did not get management or senior leadership approval were not provided.
    - System barriers and navigation challenges were documented and discussed at weekly huddles between the IAS team and government representatives. Detailed participant-specific information was not consistently shared with IAS Steering Committee throughout the pilot.

Creative solutions devised by the IAS team, as well as barriers and gaps identified within systems through their direct work with participants, were documented and discussed weekly with leadership from Manitoba Families and WRHA. High-level information from these meetings was shared at the IAS Steering Committee monthly meetings, later used to inform community-proposed creative solutions.

As defined in the IAS Steering Committee's Terms of Reference, part of the Committee's role and mandate was to oversee the "provision of supports and services to project participants through the IAS pilot for the purpose of assessing responsiveness to each individual's identified needs and for developing recommendations to government."
Throughout the pilot, community representatives often expressed that high-level updates occasionally provided by government representatives about the types of needs and trends

experienced by participants were insufficient to meet the intent of the Terms of Reference. They noted that the lack of detailed information and consistent or complete data, as well as the inconsistent approach to data sharing, limited their ability to fully contribute to identifying and shaping creative solutions during the pilot.

Government representatives decisions regarding information sharing were guided by a cautious approach to protecting participant confidentiality. While information was shared with the Steering Committee when deemed appropriate, representatives remained concerned about the possibility of inadvertently identifying IAS participants, including through the release of anonymized or detailed data. These limits were viewed as necessary to comply with The Freedom of Information and Protection of Privacy Act (FIPPA) and The Personal Health Information Act (PHIA), which limit the disclosure of personal and personal health information.

Alternative methods for sharing detailed information, such as using participant confidentiality waivers, explicit authorized consent and anonymization of information, were suggested by community representatives at Steering Committee meetings. While these approaches were discussed, they were not pursued due to government concerns regarding legal and ethical requirements under the current privacy framework, as the additional participant-level information sharing was not requested at the beginning of the pilot, and several participants declined to participate in evaluation. The inability to share more detailed information led to a certain level of frustration for community representatives.

Timeline of Community-Proposed Creative Solutions

In May 2023, IAS Steering Committee community representatives expressed concern that the pilot was not meeting its aim of emphasizing creative solutions. Based on their experience and expertise, they identified several areas that required additional focus in the implementation of the pilot, including the way services are accessed (one-door approach) and directed (self-direction and individualized approach), among others.

Community representatives also observed that many creative solutions put forward by government representatives focused on making exceptions to current policies and practices, which they noted may have limited scalability. They also expressed their interest in participating in a collaborative process to develop creative solutions, from the standpoint that such solutions should change or, at a minimum, contemplate changing systems, policies and practices.

In July 2023, they initiated an innovation process to identify creative solutions led by a facilitator, which was agreed to and undertaken by the Steering Committee as a whole. This initiative focused on generating ideas informed by the lived experiences of individuals and, in their view, it identified innovative and reflective creative solutions. However, the process was discontinued, as many of the solutions extended beyond what government considered implementable within the pilot's timeline and scope.

Following this, IAS Steering Committee community representatives independently developed a list of creative solutions for government partners to consider in pilot implementation. They attempted to provide suggested actions which in their view could be implemented within current systems and for the 30 pilot participants. Their intention was to propose more actionable options that responded to the needs of IAS participants based on the high-level information received. From their perspective, many of the proposals focused on practical and smaller-scale adjustments to better understand the feasibility of broader system changes.

In February 2024, they submitted a proposed set of creative solutions. These proposals were grounded in:

- High-level information about participants' needs and challenges identified from weekly huddles with the IAS team.
- Barriers and gaps identified in the original complaints filed with the Manitoba Human Rights Commission.
- Results from community engagement completed by Chalet Point Consulting.

This list identified 12 areas where creative solutions were needed to respond to participants' needs:

Transportation
- Implement consistency in travel allowances (i.e., mileage and other transportation supports) between different government programming. Travel supports should be reflective of geographical differences.
- Reduce wait times by empowering the IAS team to be able to authorize transportation allowances and supports, in accordance with the government's comptrollership framework. For example, the IAS team could have authorization to approve transportation amounts up to the maximum amount approved in the Financial Manual of Administration.

Silos/One-door Approach
- Implement better service coordination and reduce wait times by empowering the department of first contact to pay for the service, and resolving "jurisdiction" and payment disputes after, without delaying, denying or disrupting the individual's service. For example, interdepartmental transfers etc. could be used to reconcile budgetary issues.
- Authorize certain services/supports immediately, in accordance with the government's comptrollership framework.

Equipment
- Implement flexibility in current funding agreements in order for individuals to be able to use supplemental funding to cover equipment that falls beyond the current funding agreements.
- Empower the IAS pilot leads to authorize equipment expenditures, in accordance with the government's comptrollership framework. For example, the IAS team could have authorization to approve equipment amounts up to the maximum amount approved in the Financial Manual of Administration.
- Request research team to look into the Alberta model of empowering clinicians to prescribe equipment without additional DHSU approval.

Self-Direction/Management
- For project participants who have funding (e.g. for respite), allow for greater freedom in how funds are spent.
- Clearly disclose how much money is available in budget so individual may be empowered to make purchase choices without having to apply, then potentially get denied for being over budget.
- Use of supplemental funding to fill gaps in service for those without dedicated funding.

Health care support and advocacy
- Dedicate staff resources to pilot health care support staff for participants' medical appointments.

Eligibility for services
- As default, enrol participants in programs based on need, instead of as an exception to the existing eligibility requirements on an exceptional basis.

Clinical supports
- Dedicate staff and empower clinicians to prescribe and approve supports without adding additional layer of approval.
- Allow individuals to access clinicians with specialized knowledge outside of jurisdiction.

Delivery of services
- Empower staff to proactively suggest supports that meet participants hierarchy of needs (spiritual, mental, physical, social and essential) and provision services accordingly.
- Greater communication with all staff within system to understand the point/goal of program.

Mental health supports
- Offer mental health supports on proactive basis with no cap on hours or sessions.
- Remove all eligibility barriers for mental health supports.

Home modifications
- Make 30 persons in pilot project eligible for home modifications up to either the amount given in other comparable programming (i.e. funding available for seniors for home modification) or in accordance with the comptrollership framework.

Care hours/supports
- Provide more hours as a blanket policy.
- For those who require it, fund options for services to support self-managed care.
- Proactively suggest homecare supports to help with additional supports as needed.
- Provide data to steering committee on how many additional hours people are getting, and what are they getting homecare to do for them that they were not previously getting.

Housing

- Proactively provide information to participants on accessible housing options and available funding supports (e.g. Rent Assist).
- Provide information to steering committee on participants who were/are in hospital, and what was barrier to them getting out of hospital.

The IAS Steering Committee put considerable effort into collaboratively workshopping this list of creative solutions. However, differing interpretations and expectations meant that common understanding was not achieved for several proposals. As a result, some solutions were not sufficiently developed to be trialed within the pilot.

Community representatives were advised by government partners that many of the creative solutions within these thematic areas could not be explored further due to funding constraints. In July 2024, they submitted a request for supplemental funding to the Manitoba government to allow the pilot to trial these creative solutions.

In December 2024, Manitoba Families and Manitoba Health, Seniors and Long-Term Care communicated that the departments were unable to increase financial support for the pilot beyond the original funding agreement.

Review by Thematic Area

Community-proposed thematic areas and creative solutions have been reorganized solely for clarity and structure purposes, progressing from solutions of general application (applies to most participants) to participant-specific (may apply to some participants). Each thematic area outlines:

A. IAS Team: Actions taken by the IAS team to respond to service requests and identified needs from the beginning of the pilot. These were brought forward to government representatives if necessary for approval or exceptions.

B. Community-Proposed Creative Solutions: Short and long-term solutions, proposed by IAS Steering Committee community representatives in February 2024, to be considered for implementation within the parameters of the pilot.

C.. Identified Barriers: System and service challenges identified by the IAS team while working with participants and seeking access to programs and supports, as well as barriers to the implementation of community-proposed creative solutions.

Methodological Note: To inform this section, government staff used a mixed-source analysis framework to examine solutions sourced and implemented by the IAS team. This framework provided a foundation for analysis by comparing information from various data sources, ensuring the information is reliable and accurately represents the work of the IAS team, as outlined below:

- **In-depth interviews:** Interviews were conducted with IAS team workers, structured around the 12 key thematic areas identified, and explored the team's collaborative efforts to navigate the systems in place.
- **Cross-reference with updates document:** Interview findings were then cross-referenced with the ongoing updates document, created at the start of the pilot and shared with government leadership during their weekly huddles. This document provided an up-to-date anonymized record of needs identified, service coordination, challenges encountered, and solutions trialed throughout the pilot for each participant.
- **Validation workshops:** Government representatives met with three members of the IAS team to review lessons learned throughout the pilot and discuss the creative solutions implemented for each participant ("storytelling").
- **Case notes:** Information about participant-focused creative solutions were verified by a review of case notes and service plans conducted by the IAS team.

Creative Solutions – General Application

1. One-Door Approach

A. IAS Team

From the start of the pilot, IAS coordinators attended to participants' needs by providing a single-entry point for all service requests. In addition, they were authorized to approve certain services and supports upfront, primarily within Manitoba Families' CLDS or WRHA's Home Care programs. These included supports such as Community Therapy Services (CTS), Supported Independent Living (SIL) and WRHA Home Care hours, or rent top-ups, aiming to eliminate delays caused by inter-departmental boundaries.

Based on their experience within the systems, the team approached service requests keeping potential systemic complexity in mind, while keeping their commitment to find workable solutions and avoiding unnecessary barriers to accessing supports. When they could not approve services upfront, rather than denying access, they kept a "maybe" approach, reassuring participants that all possible options would be explored and that they would follow up with appropriate service options in due time.

IAS coordinators recognized the importance of this approach and its alignment with the person-centred principle of the pilot. They described a consistent effort to respond positively to participant requests, prioritizing flexibility and aiming to explore all possible options to meet participants' needs.

The one-door approach was facilitated by the intense case coordination support provided by the IAS team that helped empower the pilot participants and their journeys throughout their time in the pilot. This level of coordination was possible because the IAS team had a reduced caseload (managing 30 participants between two coordinators) compared to the average in WRHA and Manitoba Families' programs.

B. Community-Proposed Creative Solutions

"One-door" was the umbrella term used by the community representatives of the Steering Committee to advocate for an integrated and more formalized model for responding to requests and improving access to services. This approach called for:

- Implement better service coordination and reduce wait times by empowering the department of first contact to pay for the service, and resolving "jurisdiction" and payment disputes after, without delaying, denying or disrupting the individual's service. For example, interdepartmental transfers etc. could be used to reconcile budgetary issues.
- Authorize certain services/supports immediately, up to the maximum amount approved in the Financial Manual of Administration.

C. Identified Barriers

While this approach was beneficial to participants, it also revealed the siloed structure of government disability services, particularly between Manitoba Families and WRHA. This separation made it difficult to bridge the gap between the two systems, as a former member of the IAS team noted.

IAS coordinators were allowed to approve certain services and supports upfront. However, these were not up to the maximum amount in the Financial Manual of Administration, but rather through funding guidelines based on assessed needs. This is because the Financial Manual of Administration is a government comptrollership document (it oversees internal financial controls) rather than a program document, and therefore, it does not set program funding maximums. Funding guidelines levels are established by the policies of each program, generally intended to be needs-based and are not necessarily subject to a fixed maximum.

At times, the IAS team needed to coordinate with other programs or different units (for example, the Disability and Health Supports Unit within Manitoba Families) to facilitate access to services for participants, which could occasionally result in delays. As such, the process was not always seamless, creating limitations to the full implementation of the one-door approach in practice.

The intensive coordination provided by the IAS team enabled participants to better navigate existing systems and access supports that might otherwise have been difficult to obtain. While this approach demonstrated the value of coordinated, person-centred service navigation, Steering Committee community representatives have noted that navigation alone did not address many of the systemic barriers identified through the human rights complaints and community engagement.

2. Eligibility for Services

A. IAS Team

The IAS team collaborated to respond based on need, enrolling participants in services according to their individual functional needs rather than strictly adhering to program eligibility requirements, particularly those outlined by CLDS (Manitoba Families) and Home Care (WRHA). With the purpose of facilitating access to participants who did not meet certain program requirements, they took a needs-based approach rather than eligibility based. This meant that most participants were offered services typically funded through program budgets based on assessed functional needs without "formal" enrolment in said programs: IAS participants accessed disability services as part of the pilot (based on assessed needs) rather than through the programs themselves.

At a system level, many individuals with complex disability-related needs do not qualify for government programs, as eligibility criteria is governed by specific policies. For example:

- Manitoba Supports for Persons with Disabilities (MSPD), an income support program for persons with severe and prolonged disabilities, requires all applicants not automatically eligible to complete a financial and disability impact assessment to determine eligibility.[4]
- Attempting to solve this potential barrier for IAS participants, Manitoba Families approved automatic enrollment into MSPD for participants who were financially eligible, without having to complete a disability impact assessment. This supported the pilot's person-centred approach, aiming to reduce barriers to accessing services.

B. Community-Proposed Creative Solutions

Community representatives of the Steering Committee proposed that eligibility for services within IAS should be based on individual need rather than granted as an exception. Specifically, they recommended:

- As default, enrol participants in programs based on need, instead of as an exception to the existing eligibility requirements on an exceptional basis.

C. Identified Barriers

While IAS participants were enrolled in MSPD without further assessment, other programs continue to present eligibility barriers to enrolment. In particular, the CLDS Assessment and Eligibility Policy (Manitoba Families) establishes that an eligible individual must be an adult living with an intellectual disability as defined under The Adults Living with an Intellectual Disability Act (ALIDA).[5] Therefore, most IAS participants did not meet formal CLDS eligibility criteria and could

4 Automatically eligible individuals are those who are receiving EIA Disability and one or more of the following qualifying disability supports: CLDS, living in a personal care home, and/or receiving Canada Pension Plan disability benefits.

5 ALIDA defines intellectual disability as "significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour both of which manifested before the age of 18 years but excludes an intellectual disability due exclusively to a mental disorder as defined in section 1 of The Mental Health Act". The CLDS program applies the ALIDA definition to determine eligibility.

not be formally enrolled as CLDS participants.

In situations where participants did not meet CLDS eligibility requirements, the IAS team figured out ways to facilitate access to supports through advocacy within systems and by using agency and community-based resources if needed. These efforts resulted in various participants being able to access CLDS-funded services despite eligibility limitations. Details on barriers and workarounds are further explored in participant-specific thematic areas.

3. Delivery of Services

A. IAS Team

Service planning and delivery were guided by each participant's discovery meeting and follow-ups. As discussed, discovery meetings differed from formal assessments typically used by the WRHA or Manitoba Families. WRHA Home Care uses an assessment instrument known as interRAI Home Care (RAI-HC) to inform individuals' needs and guides care and service planning, and CLDS uses Supports Intensity Scale Adult Version (SIS-A, a standardized assessment tool) to identify the support needs for individuals receiving CLDS services in Manitoba.

Instead of following a fixed set of questions about their medical history or diagnoses, discovery meetings focused on what individuals were willing to share with the IAS team, in an effort to be more flexible and person-centred understanding of their needs and goals. Information from discovery meetings gave the IAS team a foundation to proactively suggest supports.

The collaborative approach given to discovery meetings led by the IAS team enhanced communication between Manitoba Families and WRHA, supporting joint planning and coordination of services based on the needs identified through these meetings. In addition, follow-up meetings allowed IAS coordinators to connect with participants to ensure person-centred service delivery throughout the pilot.
The IAS team's approach to service planning and delivery can be illustrated through their work on employment supports:

- Seven participants requested assistance with accessing employment or vocational supports. IAS coordinators suggested supports based on each individual's preferences and needs.
- If the IAS team identified an employment agency able to provide services but the participant felt it would not be a good fit, or if participant did not meet the agency's eligibility criteria, then other options were explored and they suggested other programs. Three participants were referred to different agency-based employment supports (e.g., Connect Employment Services, Canadian Council on Rehabilitation and Work services).
- In one case, the IAS team arranged interpretation for a participant's job interview, assisted with meetings with employer, and arranged ongoing vocational supports through an external agency.
- IAS coordinators also advocated to accommodate another participant's job duties within their Home Care hours, coordinating with Home Care to explore options for a consistent staff schedule.

This approach to ensuring services put in place met participants' needs was applied across different types of supports, including cases where participants requested holistic supports, such as life skills, vocational or interpersonal relationships training. These efforts to offer adequate service options are reflected throughout all participant-specific areas.

B. Community-Proposed Creative Solutions

Creative solutions brought forward by community representatives on the Steering Committee recommended broadening this person-centred approach by:

- Empower staff to proactively suggest supports that meet participants hierarchy of needs (spiritual, mental, physical, social and essential) and provision services accordingly.
- Greater communication with all staff within system to understand the point/goal of program.

C. Identified Barriers

As IAS coordinators noted, implementing supports was challenging at times, as some agencies were cautious about providing services to individuals who did not meet certain criteria. Typically, CLDS-funded agencies align their internal policies with Manitoba Families' CLDS Assessment and Eligibility Policy, meaning they only provide services to CLDS-eligible individuals, that is, adults with intellectual disabilities as defined under ALIDA. Their services and programs may be limited to what is outlined in their service purchase agreements with the departments or Regional Health Authority.

Despite these barriers, the IAS team actively navigated agencies and community-based supports to identify alternatives and continuously advocated for IAS participants. Through this approach, they were able to secure services for several IAS participants that aligned with their requests and needs, even when departmental eligibility boundaries limited access, as explored in the participant-specific themes.

Creative Solutions – Participant-Specific

4. Transportation

A. IAS Team

Data sources show that 20 participants had experienced or were experiencing issues accessing or navigating transportation services. Some of them had their medical transportation covered by Employment and Income Assistance (EIA) or MSPD, and others were looking for alternative transportation options for social outings in the community other than Winnipeg Transit Plus or taxi services.

It is important to restate that all IAS participants were residing within the Winnipeg Health Region, which shaped the transportation options available to them. For example, Winnipeg Transit Plus operates primarily within City of Winnipeg boundaries, which do not align fully with the Winnipeg Health Region. As a result, participants living in areas outside the city, including West St. Paul or East St. Paul, did not have access to this service.

As navigation of transportation options was one of the main challenges encountered by participants, the IAS team assisted them in contacting, applying and booking transportation services. To help participants get transportation to attend medical appointments, the IAS teamwas involved in continuous advocacy and back-and-forth communication with MSPD.

Based on collected data, the team was able to help six participants get transportation solutions based on their needs, including:

- Securing approval to receive mileage for medical transportation through MSPD for one participant.
- Arranging transportation to medical treatments for one participant at transitional placement and after moving to a Personal Care Home (PCH).
- Obtaining approval for one participant to access medical transportation for an additional year through MSPD with support from agency.
- Assisting one participant in navigating MSPD transportation scheduling system.
- Helping one participant renew their Transit Plus registration and supported another participant in getting a city bus pass, as requested.

For one participant, transportation needs were linked with equipment and travel planning. The IAS team, in collaboration with the participant's support network, supported out-of-province travel plans, coordinating equipment and staffing, and problem-solving as needed. They assisted in booking accessible hotel accommodations for their needs and got funding through a community organization. IAS coordinators were also available to provide support for unexpected issues, such as equipment (Hoyer lift) not working properly at the hotel.

B. Community-Proposed Creative Solutions

Steering Committee community representatives wanted the pilot to focus on ensuring transportation funding amounts reasonably reflected travel costs for people with disabilities in Manitoba. They proposed:

- Implement consistency in travel allowances (i.e., mileage and other transportation supports) between different government programming. Travel supports should be reflective of geographical differences.
- Reduce wait times by empowering the IAS team to be able to authorize transportation allowances and supports, in accordance with the government's comptrollership framework. For example, the IAS team could have authorization to approve transportation amounts up to the maximum amount approved in the Financial Manual of Administration.

C. Identified Barriers

Most of the community-proposed creative solutions could not be implemented due to government practices and policies in place, particularly:

- Social chits were set under the Employment and Income Assistance (EIA) Administrative Manual. The maximum number of chits was 24 trips per year for social activities.[6] IAS coordinators did not have the authority to vary the number of chits beyond the EIA manual.
- Transportation coverage is set individually by each program rather than the Financial Manual of Administration,[7] and changes to their frameworks would require broader policy changes beyond the pilot.
- The Manitoba government staff mileage rate compensates employees for all operative costs of using a personal vehicle for work-related travel.[8]
- EIA/MSPD travel rates are set by EIA and is listed in the EIA Administrative Manual under Section 22.3.1 Transportation - Health Reasons. These rates are meant to provide the basic assistance necessary to cover transportation to medical appointments and include built-in flexibility to account for individual circumstances and available transportation options.[9] Although Steering Committee government representatives explored options to increase this rate, higher approval was not granted due to the parameters of the manual and Treasury Board authority.

Beginning April 2025, individuals were to request pre-approved medical and social transportation rides through the Medical Transportation Unit (Manitoba Families). This process replaced the practice of providing chits in Winnipeg. IAS coordinators were given access to the Medical Transportation Unit to support navigation for standing orders.

It was emphasized that three participants raised concerns about accessing and booking transportation services through MSPD because of the EIA/MSPD system change, which the IAS team documented through their weekly updates.

Issues related to Winnipeg Transit Plus services were consistently brought up (six participants expressed concerns), but because this transportation service is funded and operated by the City of Winnipeg, the IAS team had limited ability to address them.

6 Per the EIA Administrative Manual, eligible persons were provided with "chits" to cover the period between April 1 and March 31. Beyond this provision, transportation costs for social activities were the responsibility of the participant.

7 This is a government comptrollership document rather than a program document. It does not set funding limits as these are set per each program or service area.

8 Reimbursement rates for travel on government business are set by a collective agreement between Manitoba and the Manitoba Government and General Employees' Union. The rates are updated regularly and are meant to cover all operative costs.

9 Rates are as follows: North of 53rd parallel, 22 cents per km - South of 53rd parallel, 20 cents per km. Note: Medical transportation rates were harmonized between Children's disABILITY Services and EIA prior to pilot, reflecting consistency in rates between other Manitoba Families' programs.

5. Equipment

A. IAS Team

Manitoba Families and WRHA collaborated to address equipment-related needs identified during discovery meetings and following requests. The IAS team was provided with a dedicated contact for equipment within Manitoba Families Disability and Health Supports Unit (DHSU), to streamline equipment requests for 10 participants.

IAS coordinators frequently had to advocate within and across systems to get equipment or customizations (e.g., wheelchair modifications) approved to meet participants' unique needs. The IAS team continuously advocated and navigated the system to help participants access equipment and, overall:

- DHSU approved 28 equipment requests in total for 10 pilot participants. Seven participants were approved for multiple requests. DHSU also declined eight requests for six participants.
- IAS coordinators also provided support to four participants in navigating wheelchair services through Manitoba Possible.

B. Community-Proposed Creative Solutions

In response to participant and community concerns about accessing coverage for equipment and the high costs involved, Steering Committee community representatives identified options that would allow IAS participants to receive appropriate funding. With these proposals, they intended the pilot to focus on ensuring funding amounts better reflected the actual item expenses, allow more flexibility, and reduce administrative delays:

- Implement flexibility in current funding agreements in order for individuals to be able to use supplemental funding to cover equipment that falls beyond the current funding agreements.
- Empower the IAS pilot project leads to authorize equipment expenditures, in accordance with the government's comptrollership framework. For example, the IAS team could have authorization to approve equipment amounts up to the maximum amount approved in the Financial Manual of Administration.[10]
- Request research team to look into the Alberta model of empowering clinicians to prescribe equipment without additional DHSU approval.

C. Identified Barriers

Despite having a dedicated contact for equipment requests, the IAS team found additional barriers and challenges in trying to simplify the process:

10 This is a government comptrollership document rather than a program document. It does not set funding limits as these are set per each program or service area.

- Long wait times between Community Therapy Services (CTS) assessments and DHSU approvals. Even when CTS OT/PT assessments recommended equipment, approval was not guaranteed.
- There was an added layer of complexity for IAS participants who were not eligible for MSPD or Home Care to obtain equipment coverage.
- Five participants purchased equipment or assistive devices out-of-pocket during the pilot due to not having funding in place or available equipment options not meeting their needs.

The current structure of equipment supports was described by the IAS team as disjointed, making it difficult to determine which department was responsible for specific items or funding. In several cases, IAS coordinators navigated complex processes involving multiple departments and vendors, involving a frequent back-and-forth.

Furthermore, equipment lists and funding structures vary across health regions, which can also make navigation difficult for individuals. Discussions at government level acknowledged the need for a clearer process to access equipment and harmonization of lists across Manitoba. Although an initial exploration of equipment lists was undertaken, this work was not advanced further as harmonization between regions was not feasible within the scope of the pilot.

As requested by the Steering Committee, the St.Amant Research Centre conducted a jurisdictional scan to gather information on Alberta and Saskatchewan's equipment funding models. Their findings have been summarized in a later section of this final report.

6. Self-Direction/Management

A. IAS Team

The Self and Family Managed Care (SFMC) program is offered by WRHA Home Care. SFMC enables an individual or their family to manage, coordinate, and direct the non-professional services needed to continue living at home in the community.

Through discovery meetings, the IAS team found that 10 participants already had SFMC supports in place but wanted to have more care hours, the ability to reallocate unspent SFMC funding for other types of supports and/or just support with administrative burden. These requests were brought forward at weekly huddles with government representatives for discussion.

Some participants wanted to use self-managed funds for supports related to community activities and others to meet emerging needs.

- A participant's family was able to redirect self-managed respite funding toward van modifications needed to adequately support the individual.
- Three participants expressed the need to reallocate SFMC funds for community activities, independent activities of daily living, and related supports. They were approved to use some hours for community supports and for medical appointment assistance.

B. Community-Proposed Creative Solutions

Recognizing the complexity in navigating self-managed care and funds that participants had addressed, community representatives of the Steering Committee proposed three main creative solutions to improve flexibility and autonomy for participants managing their own supports:

- For project participants who have funding (e.g. for respite), allow for greater freedom in how funds are spent.
- Clearly disclose how much money is available in budget so individual may be empowered to make purchase choices without having to apply, then potentially get denied for being over budget.
- Use of supplemental funding to fill gaps in service for those without dedicated funding.

C. Identified Barriers

The IAS team explored options for three participants who had an excess of dedicated funding for services (i.e., SFMC respite) to reallocate those unused funds. The team brought forward participant requests to department management for approval. These requests were based on the needs identified through discovery meetings and ongoing case coordination and approved correspondingly.

Participants who had SFMC funds still required a Self or Family Manager to administer them. Managing care includes responsibilities such as hiring and scheduling staff, payroll and reporting, which, according to the IAS team, often felt overwhelming for participants.

The pilot could not offer permanent solutions to alleviate this administrative burden but it did attempt to streamline processes where possible. In some cases, where two systems or programs contributed to the cost of services, WRHA and Manitoba Families established a single contract with the individual or family, managing cost recovery behind the scenes to simplify the process for the participant.

When IAS participants were interested in trying alternative options for outsourcing SFMC administrative tasks, these requests were assessed by the IAS team. Three participants were presented with an alternative option to manage services (namely, they started to explore Options for Services – administration with an external agency), but they chose to not pursue it.

As noted, the request for supplemental funding submitted by the IAS community representatives of the Steering Committee in July 2024 was denied in December 2024.

7. Health Care Support and Advocacy

A. IAS Team

From the start of the pilot, the IAS team took the role of coordinating and navigating health care supports and advocacy. These efforts included:

- Scheduling medical appointments.
- Providing direct support and accompanying participants to medical appointments if needed.
- Reaching out to agencies for additional staff support to assist participants with medical appointments and other day-to-day activities (i.e., SIL supports).

As more specific requests were made by participants, IAS team members took initiative to coordinate other supports, including:

- Facilitating Victoria Lifeline (medical alert service) requests and trials for two participants.
- Contacting dentist offices and collaborating with WRHA Oral Health Program to find accessible and specialized dentist for one participant. Navigating medical services and Exception Drug Status (EDS) to get prescription approval for one participant.
- Connecting with Family Doctor Finder to help one participant transition from pediatrician to adult family doctor.

According to the IAS team, putting these types of services in place for participants involved a higher level of advocacy with agencies and within departments to determine the best match for direct support. This level of support and advocacy extended well beyond the scope of a case coordinator's typical responsibilities and was possible because of the pilot's significantly reduced caseload.

B. Community-Proposed Creative Solutions

In response to the challenges that IAS participants had encountered in accessing and navigating health care services, community representatives of the Steering Committee proposed a creative solution within IAS to involve additional support in this area:

- Dedicate staff resources to pilot health care support staff for participants' medical appointments.

C. Identified Barriers

As told by IAS coordinators, there was a level of caution from CLDS-funded agencies to provide health care support to IAS participants, as their internal policies, practices and capacity were aligned with CLDS eligibility. CLDS-funded agencies are structured to serve CLDS-eligible individuals (adults with an intellectual disability), whose needs typically involve supported decision-making. IAS participants often required more complex physical and functional supports beyond the agencies' expertise and may not require support for decision-making.

The policies and practices of many CLDS-funded agencies explicitly limit services to CLDS-eligible individuals, as their agreements with Manitoba Families are tied to providing services to this population, creating barriers for non-eligible individuals with similar needs. However, an agency board amended its policy to allow one IAS participant to access services, although the participant was not formally eligible under CLDS. Staff from this agency were able to accompany the participant to their medical appointments.

Agency staff providing health care support services to IAS participants faced a learning curve and required flexibility to adjust to their specific needs. For example, staff may not be used to taking notes during medical appointments for participants, or providing other types of support required. Ensuring adequate supports required intense case coordination from IAS coordinators to help bridge gaps between systems and agencies and adapt service arrangements as needed.

8. Clinical Supports

A. IAS Team

IAS coordinators worked creatively to ensure that some clinical supports and programs were accessible to IAS individuals with identified needs. Although IAS coordinators described difficulties in accessing and providing funding for these types of services, they managed to provide support for participants by:

- Fast-tracking WRHA Community Therapy Services (CTS) referrals for six participants. CTS therapy assessments were supported where there was a new need for assessment and equipment.
- Leveraging physiotherapy plans (exercise programs) through CTS, including OT/PT assessments and support from health care aides to deliver programs, for five participants.
- Supporting applications for outpatient physiotherapy services at Health Sciences Centre (HSC). Two participants were approved for services through HSC.
- Securing funding for short-term access to a mobility program at the Movement Centre of Manitoba for one participant through CLDS clinical funding.

B. Community-Proposed Creative Solutions

Grounded in IAS participants' experiences as well as identified gaps in access to clinical services, the IAS Steering Committee community representatives proposed two creative solutions to be implemented in IAS:

- Dedicate staff and empower clinicians to prescribe and approve supports without adding additional layer of approval.
- Allow individuals to access clinicians with specialized knowledge outside of jurisdiction.

C. Identified Barriers

Access to clinical supports was often limited by system boundaries and approval processes, similar to other areas. IAS could not support coverage of out-of-province providers for therapy and specialized clinical services due to insurance limitations and regulatory restrictions from professional clinical bodies in Manitoba.[11]

11 Health professions are regulated provincially. There is no national framework that allows seamless interprovincial access to specialized clinical services without regulatory and insurance barriers. The Health Services Insurance Act governs the Manitoba Health Services Insurance Plan, which defines "benefits" as those designated in regulations and available only within Manitoba, unless explicitly approved. Non-hospital therapy services are not generally covered. Even if approved, coverage is limited to standard rates and private services are excluded.

As explained by an IAS coordinator, clinical supports were not typically streamlined, particularly through CTS or outpatient programs at HSC, and there is limited coverage for the latter option. Three participants had private insurance coverage or were paying out of pocket for physiotherapy services.

In general, Manitoba has limited availability of allied health professionals with expertise working with adults with disabilities. For example, outpatient programs at HSC are limited and, aside from CTS, there is no publicly funded programming specifically organized around the needs of all adults with disabilities.

Even when supports were approved for IAS participants, they did not always provide long-term feasibility. For example, two individuals faced additional challenges following their exercise programs and would require ongoing support or additional staff assistance to fully benefit from them.

9. Mental Health Supports

A. IAS Team

Early in the pilot, discovery meetings showed that mental health was one of the most significant concerns among participants at different levels, with eight participants identified as having mental health needs during their initial meetings or later in the pilot.

While three individuals were enrolled in WRHA Community Mental Health Services (CMHW) or Shared Health's Community Forensic Mental Health Service program prior to joining IAS, others expressed a general need to access mental health services. IAS coordinators began liaising with different programs and agencies to find adequate supports for participants' mental health needs, including:

- WRHA Community Mental Health Services, which provide supports to adults with severe and persistent mental health problems through a variety of service models.
- The Canadian Mental Health Association, which provides a variety of mental health services in Manitoba.
- External programs that offer counselling and related services.

The IAS team advocated and proactively navigated mental health services and, as a result, 11 participants received appropriate services. IAS coordinators did this by:

- Helping two participants with their applications to WRHA's mental health program.
- Providing four participants with information on counselling and mental health resources through non-profits and different organizations or agencies.
- Securing counselling services for three participants based on their requests or assessed needs. One additional participant was offered counselling services but chose to decline.
- Referring one participant to the Short-Term Assessment and Treatment Program at the Health Sciences Centre.

- Facilitating agency-based cultural services for one individual who preferred this broader approach after discussing and considering other options, such as counselling with an Indigenous Elder.

B. Community-Proposed Creative Solutions

To address the need for access to mental health supports for IAS participants with mental health challenges, the community representatives of the IAS Steering Committee proposed two creative solutions:

- Offer mental health supports on proactive basis with no cap on hours or sessions.
- Remove all eligibility barriers for mental health supports.

C. Identified Barriers

Government-funded mental health services, including WRHA Community Mental Health, are designed to help individuals with severe and persistent mental health challenges. Accordingly, access to these services is determined by priority rating (i.e., priority is given to those with the most significant assessed needs) and system capacity. Given the broad public demand for mental health supports, the pilot was unable to offer unlimited hours or sessions, nor could it remove eligibility barriers for participants.

Despite these limitations, IAS coordinators were able to offer access to counselling services and extensions based on participants' needs. In addition, a contact with WRHA Community Mental Health was created for the IAS team to help navigate different resources within and beyond program boundaries.

10. Home Modifications

A. IAS Team

The IAS team documented four requests for home modifications and explored potential funding options, including external grants such as:

- Manitoba Safe and Healthy Home for Seniors Program, funded by Manitoba Health and delivered by March of Dimes Canada, which provides funding for low-income seniors for basic and essential devices or adaptations within their homes.
- Residential Adaptations for Disabilities Program, delivered by Manitoba Housing, that provides financial assistance to low-income homeowners or landlords with low-income tenants to make adaptations to homes and housing units for people with disabilities.

None of the participants that needed funding for home modifications qualify for these options due to age and income thresholds. Some participants had paid for their own modifications prior to entering the pilot (e.g., a participant had paid for their own ramp), and two participants covered modification expenses during the pilot, including for a lift installation and a washroom renovation, as they were not eligible for alternative programs.

B. Community-Proposed Creative Solutions

Community engagement showed that many persons with disabilities do not receive funding support for home modifications, and IAS participants shared similar concerns. The Steering Committee community representatives aimed to ensure participants could access home modifications at a level that was responsive to actual costs. To address this, they suggested:

- Make 30 persons in pilot project eligible for home modifications up to either the amount given in other comparable programming (i.e. funding available for seniors for home modification) or in accordance with the comptrollership framework.

C. Identified Barriers

In practice, the comptrollership framework does not establish guidance for home modifications funding and existing policies do not scope these types of requests. There is currently no program within Manitoba Families or Manitoba Health, Seniors and Long-Term Care that provides dedicated funding for home modifications for adults with disabilities.

While neither department provides direct funding to persons with disabilities for home modifications, low- to moderate-income individuals aged 65 or older can apply for grants through the Safe and Healthy Home for Seniors Program (funded by Manitoba Health, Seniors, and Long-Term Care). If eligible, they may apply for up to $5,000 for basic and essential accessibility solutions and up to $6,500 if they live in a rural or remote area.[12]

Expanding the eligibility criteria to include younger people with disabilities would involve changing the funding agreement with the third-party organization and the purpose of the program itself. These changes were beyond the scope of the IAS pilot.

The IAS team's navigation helped participants explore other options for home modifications, but the systemic barriers encountered in the process emphasized the need for accessible home modifications funding mechanisms specifically designed for adults with disabilities.

11. Care Hours/Supports

A. IAS Team

The IAS team identified that 20 participants required additional WRHA Home Care hours and/or SIL support hours. Based on assessed needs, requests for additional care hours were escalated to government representatives within WRHA and Manitoba Families for approval. According to available data, the increase in hours was as follows:

- WRHA Home Care hours were increased beyond the 55 hours per week maximum. Six participants received an average of approximately 28.5 additional hours per week in response

12 Every three years, up to a lifetime maximum of $15,000.

to assessed needs.
    - In cases where WRHA and Manitoba Families were cost-sharing services for participants, CLDS-funded family-administered respite hours were used to supplement Home Care hours.

- Similarly, SIL hours were provided according to participants' needs (i.e., assistance with various activities of daily and independent living) ranging from five to approximately 10 hours weekly per participant. In total, 14 participants received weekly SIL hours arrangements through different CLDS-funded agencies. All but one participant would have been unable to access SIL outside the pilot because they were not eligible for CLDS.

At times, the IAS team provided support by accompanying participants to appointments, booking appointments, and assisting in other health-related activities. These were not considered formal supports but were delivered directly by the team when needed, for example, when a participant did not have SIL supports in place yet.

B. Community-Proposed Creative Solutions

Based on the limitations of existing care models for people with disabilities and the need to focus on IAS participants' needs, four creative solutions were proposed:

- Provide more hours as a blanket policy.
- For those who require it, fund options for services to support self-managed care.
- Proactively suggest homecare supports to help with additional supports as needed.
- Provide data to steering committee on how many additional hours people are getting, and what are they getting homecare to do for them that they were not previously getting.

C. Identified Barriers

The IAS team corroborated that they successfully facilitated increased care hours and supports for many participants. However, they also offered insight on challenges, particularly for those participants managing their own care under SFMC, including the added administrative responsibilities. As discussed under the Self-Direction/Management theme, IAS pilot was not able to fully alleviate this administrative burden for participants and their families.

Manitoba Families and WRHA shared only high-level information with the Steering Committee to reduce the risk of indirect identification of participants. Government representatives assessed that, under the current privacy legislative framework, detailed information could have inadvertently identified IAS participants, for example, in cases where Steering Committee members were familiar with participants' circumstances.[13] At IAS Steering Committee meetings, there were times when data on care hours was shared, though inconsistently. This included specific scenarios or barriers for the purpose of identifying solutions that might meet participants' needs. However, most updates were high-level and provided general numbers.
Toward the end of the pilot, government representatives shared general data on average increase to care hours for IAS participants with the rest of the Steering Committee, as requested.

13 FIPPA and PHIA limit the disclosure of personal information and personal health information. The Acts do not authorize disclosure to entities that are not public bodies (FIPPA) or trustees (PHIA). Sharing identifiable or potentially identifiable information would have constituted an unauthorized disclosure under both Acts.

12. Housing

A. IAS Team

Throughout the pilot, the IAS team worked to proactively provide information to participants on accessible housing options and available funding supports. Additionally, IAS coordinators helped participants access rent top-ups through Manitoba Families and searched for residential placements within WRHA for participants who required it.

Housing needs varied among participants. Five participants asked for general information on accessible housing and options, while another four were looking for specific residential placements to support their care needs.

Early in the pilot, Manitoba Families and WRHA worked collaboratively by cost-sharing funding for an individual to transition from a WRHA Personal Care Home (PCH) to a group care home in community.

In total, nine participants' assessed needs and requests were addressed in various ways throughout the pilot:[14]

- One participant received community residential placement through exceptional funding approved by a hospital under a special contract.
- Two participants moved to WRHA PCH facilities from hospital.
- One individual moved to a WRHA chronic care facility after hospitalization while awaiting transition to community placement.
- Two participants received rent top-ups through CLDS funding.
- Three participants got assistance in renewing or applying for housing/rent assistance programs, including Rent Assist and the Canada-Manitoba Housing Benefit.

B. Community-Proposed Creative Solutions

Emphasizing the need for dignified housing for people with disabilities, and informed by participants experiences and research on accessible and affordable housing,[15] the Steering Committee community representatives suggested two creative solutions:

- Proactively provide information to participants on accessible housing options and available funding supports (e.g. Rent Assist).
- Provide information to steering committee on participants who were/are in hospital, and what was barrier to them getting out of hospital.

14 Note: All placements were with the participant or their legal decision maker's consent.

15 Lindsay S, Fuentes K, Ragunathan S, Li Y, Ross T (2024) "Accessible independent housing for people with disabilities: A scoping review of promising practices, policies and interventions." PLOS ONE 19(1): e0291228. https://doi.org/10.1371/journal.pone.0291228.

C. Identified Barriers

IAS coordinators emphasized that housing programs are limited, and navigating these programs was often complex and required intensive case management from them. They also recognized that housing challenges extend beyond existing program and processes, as there is a shortage of affordable and accessible housing for people with disability-related complex needs in Manitoba. At a system level, hospital discharge planning is particularly difficult, with delays often caused by the lack of suitable placements and funding.

Despite these challenges, the IAS team navigated programs to identify creative solutions, such as securing rent top-ups for participants within available resources and setting up contracts for residential placements.

Sharing detailed information about hospitalized or discharged participants with non-government IAS Steering Committee members was not possible due to restrictions on disclosure of personal health information under FIPPA and PHIA.[16] Government representatives interpreted this restrictions as necessary to prevent unintentional disclosure of personal health information and comply with the duty to protect privacy. Community representatives expressed that these limits on information-sharing reduced their ability to fulfil their responsibilities outlined in the IAS Steering Committee Terms of Reference.

Closing Summary

The IAS pilot project was designed for a small caseload composed of 30 people with complex disability-related needs with the aim to trial a new service delivery model with selected participants. The intensive case coordination provided to IAS participants was delivered by the IAS team, which was tasked with coordinating supports across Manitoba Families and WRHA and responding to needs through a person-centered approach.

While creative solutions were a key element of the pilot and a core expectation for the IAS Steering Committee, interpretations of "creative" shaped the opportunities and limitations of the solutions put forward. Community representatives expected broader innovation and testing of ideas that could later address structural barriers for people with disabilities. Government representatives approached creative solutions with the understanding that they would be based on individualized problem-solving for IAS participants within current budgets and systems.

Despite these differences and the setbacks encountered within the disability supports system, the IAS team worked creatively to identify options, advocate across systems and ensure participants had access to services they needed and requested. Furthermore, the IAS Steering Committee community representatives presented a list of creative solutions for government representatives to consider in pilot implementation.

16 As stated previously, FIPPA and PHIA limit the disclosure of personal information and personal health information.

Trialed creative solutions and challenges in implementation encountered throughout the pilot provide an overview of lessons learned:

- Intensive case coordination and a person-centred approach is most effective when staff manages a small caseload, such as that of the pilot. However, the pilot showed that better navigation and intensive case coordination does not resolve all of the barriers related to eligibility, funding structures and other limitations embedded in the current systems.
- Needs-based exceptions, implemented as creative solutions, helped participants access services that they would generally not be eligible for. Eligibility requirements remain a barrier for individuals with similar functional needs who do not meet criteria.
- Collaboration across departments and leveraging services and supports (through the "one-door" approach) improved access to disability supports for participants. The current siloed structure of different departments adds complexity to accessing disability services.
- Improving access to some disability services, such as accessible housing supports, would require collaboration with government departments beyond those participating in the pilot.
- The barriers documented throughout the pilot provide important insight into areas where policy, program design or interdepartmental coordination may need to evolve to ensure equitable access to disability supports across Manitoba.

Chalet Point Consulting: Evaluation and Engagement Findings Summary

About Chalet Point Consulting

Chalet Point Consulting was contracted as the independent external evaluator for the IAS pilot. A four-person team, led by Dr. Terra Johnston, conducted the evaluation between 2023 to 2025. Their work had three main parts: listening to people with disabilities and families across Manitoba; assessing whether participants' quality of lives improved; and examining the extent to which the pilot contributed to learning about solutions and strategies that could inform broader system improvement.

The full Chalet Point report was submitted to the IAS Steering Committee in February 2026. It is included in full as an appendix to this final report – See Appendix C. This section summarizes the key findings and recommendations from that report.[17] Because the IAS pilot originated from human rights complaints, Chalet Point reviewed its findings through a human rights impact assessment lens. People with disabilities and family members helped shape the evaluation questions and review the findings, a participatory-based process that reflected real lived experience.

17 Artificial intelligence (AI) tools were used to support the drafting of this summary and was then edited and finalized by the Steering Committee.

Consultation with Manitobans

A key part of Chalet Point's work was hearing directly from people with disabilities, their family members and service providers across the province. These consultations revealed gaps in Manitoba's disability services system from the perspectives, opinions and beliefs of engagement participants.

Two rounds of sessions were held between November 2023 and February 2025. In total, 210 people took part across 12 sessions in Winnipeg, Brandon, Dauphin, Thompson, and Steinbach, as well as online sessions. Sessions were held in accessible formats and at different times of day to make it easier for people to attend. Organizations including the Cerebral Palsy Association of Manitoba, the Family Advocacy Network, and Manitoba Possible also helped host sessions and reach participants.

Findings from the first round of engagement were presented as part of the IAS Interim Report and 17 themes were identified through the two rounds of engagement. These themes reflect the lived/living experiences of engagement participants, as listed below:

Barriers to the Adult Disability Services System

The most common concern across the province was that many people cannot get the supports they need because they do not qualify. This was especially true for people with acquired brain injury, seizure disorders, autism, or other medical conditions that affect their ability to live safely in the community. These people often do not qualify for Community Living disABILITY Services (CLDS) or supported housing even though they may have similar needs as those served in that program.

"Hospitalization costs the government substantially more than providing supports in the community. We feel that this injustice would be remedied by changing CLdS eligibility to include all disabilities."
- Engagement participant

Many people also said that equipment covered when they were children — like wheelchair cushions or mobility aids — was no longer covered once they turned 18 years old. This gap between children's services and adult services came up in almost every session held across the province.

Inadequate Income Supports

People across both rounds of sessions said that income supports do not cover the basic costs of living with a disability. They noted that programs like Employment Income Assistance (EIA) need to be more flexible and adequately cover supports such as physiotherapy, occupational therapy, dental and eye care, respite, and basic health products.

"I'm penalized for working part time. When transitioning into adulthood and fostering independence, I began working and lost benefits and made less than when I was on EIA. Being penalized for working part time is a big issue that should be fixed in the EIA program."
- Engagement participant

Engagement participants also said that waiting up to 30 days to be reimbursed for respite services was a real hardship, given how tight their finances already are.

Future Care Planning for Families

Many parents said they have been providing care for their adult children for years because their children do not qualify for government supports. As these parents get older, they are worried about what will happen when they can no longer help. They asked the province to start planning now for this transition, before it becomes a crisis.

"I wake up at night wondering what happens when we are gone?"
- Engagement participant

Home Care Needs and Care Provider Training

People across the province, especially in rural areas, said they do not have enough access to home care hours and providers, nurses and direct support professionals. Many also said they cannot count on a consistent care worker and have to constantly train new people, which is an added strain for those with limited time and energy. Self-managed home care was largely not available to people in rural Manitoba or to those without strong family support, and the requirement to have a backup care plan before you can get home care can create a barrier for those people who lack family supports.

Disability Service Needs in Rural Manitoba and the Impact of Travel Expenses Incurred by Individuals Living Outside of Winnipeg

People from Brandon, Dauphin, Thompson, and Steinbach painted a clear picture: most disability services are available in Winnipeg, not where they live. Services like occupational therapy, physiotherapy, and wheelchair repair require long trips to Winnipeg. Public transportation for people with disabilities is unreliable, expensive, or simply not available in many communities.

"It is very difficult to get access to any health services in Brandon. And every specialist is in Winnipeg."
- Engagement participant

Coordination and Integration of Service Provision

Many people said navigating Manitoba's disability services system is fragmented and exhausting. They often deal with multiple departments and organizations, each with their own forms and processes. Some had never spoken with their caseworker in person. For people who are already managing limited time and energy, these administrative demands are a real barrier.

Transition to Adulthood Supports and Services

Several families raised concerns about what happens when young people with disabilities finish school. They described limited employment support, reduced services in some rural high schools, and a lack of life skills programs. The School Transitions Protocol was described as underfunded and inconsistently followed.

Dignified Housing Options

Nearly all participants raised housing as a major concern. Group homes and personal care homes were described as crowded and institutional. Many people said they could not get funding to make their own homes accessible (for example, installing ramps or lifts). Some said the lack of accessible housing had forced them into personal care homes, even though that was not their choice.

"Many people do not have financial resources or funding agencies to pay for home modifications or ramps. People who do not have an accessible home are hard pressed to find appropriate housing due to lack of same. People who can't access their homes and are unable to find accessible housing, typically are forced to go into Personal Care Homes."
- Engagement participant

Support for Family Caregivers

While more people with disabilities are living in the community, many families said they have had to fill gaps in formal services without any support or pay. Parents and siblings described burnout, and respite services are hard to find because there are not enough staff. Some families said they were not allowed to hire other family members as paid respite workers, even when no one else was available.

System Navigation Services to Connect People to Resources

Many parents said they have been providing care for their adult children for years because their children do not qualify for government supports. As these parents get older, they are worried about what will happen when they can no longer help. They asked the province to start planning now for this transition, before it becomes a crisis.

"It's not always reasonable to rely on family… they have their own responsibilities."
- Pilot participant

Public Buildings and Spaces

Participants pointed out that the lack of accessibility in public buildings adds another layer of difficulty to accessing services. Examples included a provincial government building offering services to wheelchair users that had no automatic door; hospitals without accessible washrooms or main entrance doors; schools without accessible interior entrances, among others. Participants called for a formal accessibility audit of public buildings across both Winnipeg and rural communities to document the full extent of this problem.

"I have both a physical disability and a mental health disability. Recently I was refused care for my mental health needs because the building was inaccessible [to the care provider]."
- Engagement participant

Manitoba Wheelchair Services

For people who use wheelchairs, a functioning and well-maintained chair is essential. Participants described wait times for wheelchair repairs and routine maintenance as challenging and the criteria as too restrictive. They also noted that as their needs change over time, adjustments and modifications need to happen quickly. Further, they called for action to address Manitoba's wheelchair services program capacity issues.

"I can't function well in the old chair. It's broken down. [Manitoba's] wheelchair services can't upgrade it even though my pads are worn. I need better back support now, and my back tires are completely bald, so I am housebound in poor weather."
- Engagement participant

Provincial Advocacy for Persons with Disabilities and Family Caregivers

Participants described being at a significant disadvantage if they did not have a family member who could advocate alongside them, and several shared stories of having concerns dismissed or ignored without support. Participants called for a provincially funded disability advocate that is independent of both government and service delivery, modelled on the Manitoba Advocate for Children and Youth or the Manitoba Ombudsman.

Mental Health Supports for Persons with Complex Disabilities

People described barriers to accessing mental health care for people with intellectual and developmental disabilities. Participants noted that those who are eligible for CLDS are often denied access to mental health services, and that Manitoba Families and Manitoba Health, Seniors and Long-Term Care operate with little coordination on this issue.

Regional Representation in Provincial Funding Discussions

Some participants from rural communities noted that the organizations that serve them have no representation in provincial funding discussions. The current process requires organizations to submit a budget based on estimated staffing hours, which can leave them understaffed if the province reduces their budget. Several participants suggested that regional representation may help government better understand the real costs and needs of organizations outside of Winnipeg.

Residential Model and Home Share Budget Issues

Participants identified that the funding model for residential care has created challenges for them. If one resident moves out or passes away, the province reduces the home's overall funding, even though the home still requires the same number of staff shifts to support the remaining residents. Organizations are left to cover those funding gaps. Participants also noted that funding amounts are not indexed to inflation or rising costs of living, and that basic personal care supplies are often not included in funding to organizations.

Mitigation Strategies for Workforce Challenges in Disability Services Sector

Participants described challenges with the disability workforce. Disability support workers are paid significantly less than equivalent workers in the broader healthcare sector, may receive insufficient training, and face growing expectations as care needs become more complex and recruitment becomes more challenging. The result of these workforce concerns are felt directly by people who rely on disability services.

What the Pilot Meant for Participants

This part of Chalet Point's work looked at whether participants' quality of life improved as a result of the pilot. Twenty-two of the 33 participants took part in an interview before the pilot began. Twenty took part in a follow-up interview after the pilot ended. Nine of these participants were explored in more depth through case studies.

What Life Was Like Before the Pilot

Participants described a set of common struggles before the pilot began:

- Loneliness and isolation - without enough support to get out in the community, many people had pulled back from social connection
- A sharp drop in services at age 18 - things that were covered in childhood became hard or impossible to access as adults
- Being dismissed because of an "invisible disability" - people with chronic pain, neurological conditions, or other non-visible disabilities said their needs were often overlooked, even when a doctor had confirmed them
- Falling through the income gap - people who worked part-time were often too "high income" to qualify for supports, but earned far too little to cover the real costs of living with a disability
- The hidden workload of disability - everyday tasks like grocery shopping took hours and used up all their energy, leaving nothing left for work or relationships
- Advocacy fatigue - years of being denied services had worn people down emotionally
- Distrust of the system -rigid rules, poor follow-through, and undignified service experiences had left many people feeling that the system was not on their side

"The transition cliff at 18 [years old] comes with reduced funding and coordination… [the adult disability services I now receive] are not enough to survive, but not enough to thrive."
- Pilot participant

How the Pilot Changed Things

For most participants (about 80%), the pilot made a real and meaningful difference to their quality of life. People said the pilot helped them by:

- Getting more home care hours, which freed up time and energy for work, social connection, and family
- Using home care more flexibly — for grocery shopping, errands, meal prep, and getting out in the community, not just personal care tasks at home
- Being treated with respect by IAS coordinators who listened, followed through, and saw them as the experts on their own needs
- Getting help advocating for themselves — accessing parking permits, physiotherapy, equipment assessments, and programs they had previously been denied
- Feeling less isolated and better mentally because they could participate more in their communities

"They treated me like a respected colleague and less like a client…and that goes a long way with me."
- Pilot participant

"I do not want to be rescued – I want to be accompanied."
- Pilot participant

"Getting a bit of support goes a long way. Saves energy so I can use it for work or social outing, which improves mental health."
- Pilot participant

About 20% of participants said the pilot did not help them or made little difference. They were frustrated that it did not give them new services and that the deeper system problems they faced remained unchanged. Their experience emphasizes that a person-centred approach, although helpful, cannot fix systemic barriers on its own.

"I didn't need help navigating the system – I wanted to change the system so it didn't need navigating."
- Pilot participant

What the Case Studies Showed

The nine case studies covered a wide range of people: those living independently, those in supported housing, people working full and part-time, and people managing chronic pain, acquired disability, physical disability, and conditions that are visible from the outside. Across all of them, the same themes kept coming up:Even a small increase in home care hours made a big difference to independence, mental health, and quality of life

- The relationship with the IAS coordinator mattered enormously — warmth, follow-through, and respect for the person's choices were what participants valued most
- When staff changed mid-pilot, it was disruptive. Having to explain your disability and your needs again to a new worker was, for some participants, emotionally difficult and sometimes traumatic and stressful
- Transportation was a barrier that the pilot could not fix and that affected people throughout
- Many participants worried about what happens when the pilot ends and they return to the system they knew before

A Human Rights Impact Assessment

Because the IAS pilot was developed as part of a human rights settlement agreement, Chalet Point reviewed the case study findings against the United Nations Convention on the Rights of Persons with Disabilities, of which Canada is a signatory. Here is what they found:

- Right to live independently in the community: Before the pilot, many participants were at risk of losing their independence. Flexible home care through the pilot helped, but accessible housing, which is essential to independent living, remains a serious unresolved problem across Manitoba.
- Right to move freely: IAS services helped people get around and participate in their communities. Accessible public transit and timely wheelchair maintenance are still major gaps.
- Right to rehabilitation and health: Access to physiotherapy through the pilot was valued, but many participants said they need preventative health support to stay independent over time — not just treatment after problems develop.
- Right to work: Flexible support through the pilot helped people conserve energy for their jobs, but the current system penalizes people for working part-time by making them ineligible for supports. This needs to change.
- Right to an adequate standard of living and cultural participation: Financial strain and barriers to community participation came up throughout the evaluation. These are systemic issues that go beyond what the pilot alone can address.

"I think this is a valuable project… I would love to see it be absorbed mainstream for more people to access."
- Pilot participant

How the Pilot Ran

This part of Chalet Point's work reviewed how the pilot was set up and managed. Data was collected across two rounds: March to May 2024 and April to July 2025. A total of 79 people took part, including pilot participants, IAS coordinators, and Steering Committee members from both government and community.

What Worked

- The process for selecting participants was well done, with good representation across age, gender, housing situation, and type of need
- The initial assessment process was experienced by most participants as welcoming and respectful, a real contrast to previous service experiences
- Having a WRHA nurse and a Manitoba Families worker on the same team helped with coordination and flexibility
- The ability to give participants more home care hours than the usual limit was one of the most valued parts of the pilot and had a direct impact on outcomes
- People with lived experience were represented on the Steering Committee, and their presence brought important accountability to the pilot

A Fundamental Disagreement on What the Pilot Was For

A significant problem throughout the pilot was that government and community representatives had different understandings of what the pilot was supposed to achieve.

Government representatives saw the pilot as a chance to improve how services are delivered within the current system. Community representatives saw it as a chance to try new approaches that could be used to design a new system. This gap, between improving what exists versus exploring something new, created ongoing tension that was never resolved.

There were also different expectations about what information should be shared within the Steering Committee. Community representatives felt they needed access to participants' service needs, consistent with their understanding of the Terms of Reference. Government representatives said privacy rules prevented sharing this information. Because the Terms of Reference did not clearly define this role, this disagreement and ambiguity persisted throughout the pilot.

"There were no true barriers to sharing de-identified information. I think nerves and anxiety from government prevented transparency."
- Community representative of the IAS Pilot Project Steering Committee

Further, community representatives, especially those with their own experience of disability, said their input was often not reflected in decisions. They felt that real decision-making power sat with government, and that they were included in name only.

"As community members, we were just tokens there. Even government reps at the table didn't have decision making power."
- Community representative of the IAS Pilot Project Steering Committee

Government representatives understood the frustration but said many decisions were being made at levels above the Steering Committee and that they had real constraints around risk management, legislation and financial accountability.

"Our mandate requires us to manage risks and ensure we're aligned with legislation."
- Government representative of the IAS Pilot Project Steering Committee

Chalet Point noted that both sides had legitimate perspectives.

Sustaining the Positive Impact

Chalet Point asked Steering Committee members and IAS team members to rate the pilot across several dimensions. Factors of representation of stakeholders and lived experience, person-centred considerations of services, accessibility, and friendliness were rated highest, while timeliness, replicability, and sustainability were rated lowest.

The person-centred approaches that worked well in the pilot were identified as strengths, but respondents also said these approaches would not likely carry forward on their own. Government representatives acknowledged that scalability could be a barrier to adopting pilot initiatives system-wide without significant additional resources.

"While case management works in a pilot, scaling it across the province is a different matter."
- Government representative of the IAS Pilot Project Steering Committee

Chalet Point found that all respondents agreed the pilot's strengths require strategic direction, sustained resourcing, political commitment, and policy changes if they are to be replicated post-pilot.

Recommendations

The following recommendations come from each part of Chalet Point's work. The full detail is in the Chalet Point report (Appendix C).

From Community Engagement

The 17 engagement themes covered above capture what people across Manitoba told Chalet Point about how the system needs to change. People called for broader eligibility, better income supports, more accessible housing, stronger transitions to adulthood, real support for family caregivers, and services that are coordinated rather than siloed. The full set of engagement-based recommendations can be found in the full Chalet Point report.

From the Review of Pilot Operations

- Invest more in promoting future pilots and do not rely mainly on community networks to spread the word
- Expand possible future pilots to include rural and northern Manitoba, not just Winnipeg
- Address delays in recruitment, assessment, and service start-up
- Write clear, specific terms of reference for any community-government committee, including who can see what information and who makes which decisions
- Make sure senior government decision-makers remain actively involved throughout the process
- Build in plain-language research updates so steering committee members stay connected to the evidence throughout

From Pilot Participants

This is what participants said they need from the disability support system:

- Facilitate peer support so they can learn from others with similar experiences and build their own confidence in advocating for themselves.
- Help recruiting and managing home care workers, in addition to the additional hours of home care support.
- Support finding accessible housing.
- Rules that allow care workers to go out in the community with them, and allow home care hours to be used for meaningful community participation.
- Design the assessment process for service applications to allow for open-ended responses to focus on their needs in their own words to demonstrate eligibility for programs. A system that helps them thrive, not just survive. Safety matters, but so does dignity and belonging.
- Smoother transitions from youth to adult services that ensure continuity of services.
- Better working conditions for support workers so there is less turnover, because re-explaining your disability to a new worker over and over again is exhausting and painful.
- Support that lets their family relationships be about love and connection, not just caregiving.
- Recognition that living with a disability costs more, and that this financial reality needs to be part of how the system is designed.

Overall Assessment

For most participants, the IAS pilot improved their quality of life through more flexible support, better coordination, and workers who treated people with dignity. For many, even a small amount of additional help made a meaningful difference to their independence, their mental health, and their relationships. To this end, the pilot achieved its intended goals. However, the case studies showed that there were challenges in the pilot. One commonly cited limitation was staff turnover that caused disruption and psychological distress to participants.

At the same time, the pilot struggled due to the challenges of shared community-government decision-making. The tension between different approaches to creating and implementing the pilot was not resolved and it remained a barrier to true collaboration.

Chalet Point's findings come from 210 community engagement participants, 22 individual interviews with pilot participants, and 79 people who took part in the operational review. Together they tell a consistent story: Manitoba's current adult disability services system is not working for many people with complex needs. The IAS pilot showed what is possible when supports are flexible, coordinated, and person-centred, while also emphasizing the work still required to improve the current disability supports system.

St. Amant Research Centre Research Report Summary

The St.Amant Research Centre (SARC), in their role of research services provider to the pilot, produced a systematic review of peer-reviewed and grey literature, including comprehensive jurisdictional scans. This research was conducted as requested by the IAS Steering Committee to address both immediate implementation questions and longer term systemic change priorities.

SARC submitted a two-part summary with results of their academic research, literature reviews and jurisdictional scans to be included in the IAS final report. This summary has been attached as Appendix D. Below is a shortened version of key information identified by the research team through their work from 2023 to 2025.[18]

18 Artificial intelligence (AI) tools were used to support the drafting of this summary and was then edited and finalized by the Steering Committee.

Part 1: Research Findings (2023-Early 2025)

SARC began their research duties by reviewing literature and conducting jurisdictional scans on eligibility and care models, equipment access, and housing. These topics were proposed by the IAS Steering Committee in response to early trends and themes observed in the pilot and the need to explore creative solutions.

1. Intake and Assessment Methods for Adult Integrated Care

- Evidence (in particular, the 2022 National Institute for Health and Care Excellence (NICE) review) supports individualized, person-centred intake processes, emphasizing:
    - Clear communication of purpose and process
    - Accessible formats and plain language
    - Adequate preparation time
    - Flexibility and optional self assessment with supports

- The NICE review recommends that effective assessments are flexible, collaborative, transparent and responsive to individual circumstances and preferences, rather than standardized or rigid.

2. Self Directed Care (SDC) Models in Canada

- The 20 Canadian SDC programs analyzed in the literature (in particular, the Kelly et al. 2020 article) are varied in terms of:
    - Who manages funds (e.g., individuals, family members, legal representatives or other third parties)
    - Allowable expenditures (4 out of 20 allow equipment purchases)

- Individualized funding models are broader in scope than home care or respite, and offer the greatest flexibility, supporting personal care, social participation and individualized supports.
- In Manitoba, In the Company of Friends offers an individualized funding model, though eligibility is limited (Microboard requirement).[19] The funding amount can be allocated toward support worker wages, training and equipment costs.
- Evidence suggests that individualized and flexible funding models are better aligned with autonomy, participation and responsiveness to changing needs.

3. Equipment Access in Saskatchewan and Alberta

- Saskatchewan
    - The Saskatchewan Aids to Independent Living (SAIL) program provides people with physical disabilities and complex needs a basic level of coverage for disability related equipment. The Equipment Loan program provides no-cost equipment loans with a referral from an occupational therapist or physiotherapist.

19 A Microboard is a group of family and friends joining with a person with a disability to help designed individualized and customized supports.

- If individuals need highly specialized equipment or prefer to buy their own, they are responsible for financing it or seeking support from non-profits.
- The Adaptation for Independence program provides financial assistance to low-income households to improve accessibility of a home.
- Individuals cannot purchase equipment with direct funding.

- Alberta
  - The Alberta Aids to Daily Living (AADL) program provides partial funding for equipment (25% cost share, though there are income based exemptions).
  - Individuals must be assessed by an AADL health care provider and choose their equipment from approved vendors. Additional item costs (e.g., upgrades) are covered by the individual.
  - The Residential Access Modification Program (RAMP) provides home modification supports for low-income individuals.
  - Administrative reforms post 2022 reduced AADL wait times significantly.

4. Eligibility Criteria and IQ Requirements

- Most provinces use IQ based eligibility identical to Manitoba Families' Community Living disABILITY Services.
- Notable exceptions:
  - British Columbia: Provides supports for individuals with FASD or ASD who do not meet IQ criteria.
  - Nova Scotia: Broadest eligibility, including physical disability, mental illness and acquired brain injury.

- The research documented difference in criteria but did not assess comparative outcomes across eligibility models.

5. Accessible Housing

- As general observations, the authors noted a limited number of studies directly addressing cost-benefit or social return on investment analyses related to community-based housing options for persons with disabilities and/or complex medical needs.
- A 2024 international systematic review, led by researchers at Bloorview Research Institute (Lindsay et al. 2024), found that most effective approaches to accessible housing include:
  - Removing barriers through advocacy, financial help and communication with housing providers
  - Strong policies and laws that support accessibility and programs that fund home modifications
  - Practical solutions to accessibility, such as home modifications and smart home technology

- Further, the study shows accessible housing is strongly associated with:

- Further, the study shows accessible housing is strongly associated with:
    - Increased independence
    - Improved safety, physical and mental health
    - Greater community participation

- The study concluded that while there are some options available, there is an urgent need for more accessible housing for people with disabilities.

Part 2: Priority Research Topics (Mid-Late 2025)

The IAS Steering Committee identified five priority topics for the research team to focus on, based on the recommendations from the IAS interim report released in September 2025. SARC explored these topics by conducting a thorough research literature review process.

To approach the research questions throughout this section, the research team distinguished between income support models and support programs. A model is a general approach that a province or territory could use, while a program is the actual service or agency that people can access. Programs are based on a model, and some programs may use the same model.

They also explained the difference between outputs and outcomes. Outputs are the services provided, while outcomes are the benefits for those who receive the services.

1. Redressing Inadequate Income Supports

- Based on the following research questions:
    - What income support models for persons with disabilities are implemented across Canadian provinces and territories, and what are their eligibility criteria, benefit levels, and coverage of disability-related expenses (e.g. accessible housing, transportation, specialized diets, para-health services, and respite care)?
    - What data is available regarding the outcomes of these models?

- Key findings in peer-reviewed literature about income support programs across Canada:
    - Across programs, eligibility criteria were consistently described as rigid, complex, and medically oriented. These exclude people with episodic conditions like mental health disabilities.
    - Benefit adequacy remains well below poverty lines and rarely indexed to inflation.
    - Disability related costs (e.g., housing, transportation) are inconsistently covered.
    - The Disability Tax Credit, despite serving as a gateway to other supports, remains inaccessible to many low-income individuals with only a 40% take-up rate.
    - Special populations, such as women with disabilities, face particular disadvantages.

- Grey literature shows that all provinces provide disability income support programs, although these programs vary:
    - There are two types of provincial income support models: categorical disability programs and integrated social assistance, as well as a hybrid of both.
    - Categorical disability programs generally provide higher benefits than integrated social assistance, but still insufficient for economic security.

- Available output data about socio-economic indicators reveal poverty, housing instability, unmet health care needs, food insecurity and barriers to employment.
- There is no evaluation or outcome data about the direct impact of income support programs to quality of life.

2. Family Caregivers

- Based on the following research questions:
    - What formal support programs exist across Canadian jurisdictions to assist family caregivers of adults with disabilities living in community settings, including respite care services, home care supports, and caregiver training or education programs?
    - What data are available regarding the outcomes of these programs?

- Peer-reviewed research on formal support programs to assist family caregivers shows:
    - Consumer directed programs may be associated with improved caregiver mental health and reduce unmet needs and out-of-pocket expenses.
    - Higher home care use and a reduced desire for institutionalization was reportedly associated with families accessing multicomponent interventions and formal respite programs.
    - Training and support could increase caregiver competency and satisfaction. These outcomes were observed after receiving group-based training.
    - Barriers to successful program implementation are related to sustainability, funding, workforce, equity, self-management or rural-urban and socioeconomic disparities.

- Grey literature on this topic provided additional information about types of supports:
    - Formal supports to assist family caregivers (i.e., joint federal-provincial partnerships, federal tax benefits, employment insurance caregiver benefits) exist across Canadian jurisdictions.
    - Across jurisdictions, structured training and education opportunities for family caregivers are limited, and formal outcome evaluations were uncommon.
    - Major gaps identified: limited structured training or education offered to family caregivers, very limited outcomes data, and quality of life evaluation across these programs.

3. Transition Supports for Family Caregivers

- Based on the following research questions:
    - What formal transition planning programs and services do Canadian jurisdictions provide to support adults with disabilities whose primary family caregivers are aging or becoming unable to continue providing care, and what are the eligibility criteria and service pathways for these programs?
    - What data are available regarding the outcomes of these programs?

- There is no Canadian research literature about formal transition planning programs or services. However, international qualitative and systematic studies revealed:
    - Across programs, eligibility criteria were consistently described as rigid, complex, and medically oriented. These exclude people with episodic conditions like mental health disabilities.
    - Benefit adequacy remains well below poverty lines and rarely indexed to inflation.
    - Disability related costs (e.g., housing, transportation) are inconsistently covered.
    - The Disability Tax Credit, despite serving as a gateway to other supports, remains inaccessible to many low-income individuals with only a 40% take-up rate.
    - Special populations, such as women with disabilities, face particular disadvantages.

- Grey literature shows that Canada has a limited number of formal transition planning programs and services for families when caregivers can no longer provide care. However:
    - Available supports are mostly educational tools and voluntary planning resources.
    - There is no outcome data available for these resources.

- Manitoba's Continuity Care is noted as a promising community based initiative, though it lacks outcome data.

4. Rural Service Delivery

- Based on the following research question:
    - What service delivery models do Canadian jurisdictions use to provide homecare, nursing, and direct support services to persons with disabilities in rural and remote communities, including mobile services, telehealth applications, and regional service hubs?

- Studies set in Canada identify and examine various rural service delivery models, including integrated interdisciplinary teams, hybrid (technology and in-person) and informal (family) care.- Barriers to implementing rural service delivery models include factors related to geography, workforce, resources, infrastructure, or availability of for-profit services.
    - Among the study findings, reported positive outcomes among persons with disabilities and their families using different rural service delivery models to receive services included: improved self-efficacy and health, greater support, flexible or cost-effective access, positive family experiences, and reduced travel.

- Grey literature shows that approaches to rural service delivery models include:
    - Telehealth and virtual care.
    - Hub and spoke interprofessional networks working regionally to provide assessment and ongoing care.
    - Traveling and mobile services that bring providers and equipment to communities on scheduled rotations.

- These models reduce travel burdens and improve access to services but depend heavily on broadband infrastructure and workforce availability.

6. Rural Staffing

- Based on the following research questions:
    - What recruitment, retention, and training strategies have Canadian provinces and territories implemented to address shortages of qualified disability support workers, nurses, and homecare providers in rural areas?
    - What are the outcomes of these initiatives?

- Literature thematic analysis of recruitment strategies revealed a variety of strategies to address shortages of qualified disability workers across Canada:
    - Recruitment strategies, including communication technologies, work environment improvements, targeted marketing, etc.
    - Retention strategies, such as stress management and continuing professional education.
    - Training and education strategies, for example, mentorship and a structured transition program for new graduate nurses.
    - Overall, there is limited outcome evaluation data.

- Grey literature shows that some jurisdictions have used workforce strategies such as:
    - Targeted financial incentives with return of service commitments.
    - Wage measures, including permanent wage enhancements.
    - Paid "earn while you learn" training incentives.

- Evidence suggests multiple strategy approaches are more effective than relying on single interventions.
- Outputs and outcomes reporting is uneven and generally limited across provinces.
- Disability support workers recruitment and retention remain under prioritized compared to nursing initiatives.

Closing Summary

Overall, the research describes similarities and differences across jurisdictions in eligibility criteria, funding and care models, supports for caregivers and rural service delivery. While SARC identified several promising practices, the report notes areas where evidence is available and where significant limitations still remain.

The results from the literature reviews and jurisdictional scans highlight considerable variation in program design, limited outcome evaluation across many service areas, and recurring challenges related to adequacy, access, coordination, and sustainability.

This report emphasized both the opportunities and barriers in service delivery for adults with disabilities and complex needs across Canada. The research findings were used to inform the development of recommendations for the Manitoba government as part of the IAS Final Report.

Key Themes Emerging from the Pilot Project

Three main bodies of work informed this final report: the creative solutions suggested and/or trialed by the IAS team directly with participants in the pilot project; the academic research and jurisdictional scans conducted by the St.Amant Research Centre (SARC); and the evaluation, engagement, and outcome research conducted by Chalet Point Consulting. These three bodies of work were conducted independently and used different methods, one grounded in direct service experience, one in peer-reviewed literature and jurisdictional evidence, and one in direct engagement with people living with disabilities across Manitoba.

The themes in this section represent what came up repeatedly, across all three sources and form the foundation for the recommendations that follow.

Theme 1: Flexible and Coordinated Support Works

One of the clearest findings across all three bodies of work is that person-centred, coordinated support makes a real difference. The IAS pilot demonstrated this in practice.

The IAS team worked with a caseload of 30 people, significantly smaller than the typical caseload in standard Manitoba Families and WRHA programs. This allowed them to take time to understand each person, explore options across systems, and follow through on requests. Their approach was built around open-ended discovery meetings rather than standardized assessments with fixed criteria, which appeared to be beneficial. Twenty participants received increased home care hours. Fourteen received weekly supported independent living hours. IAS coordinators helped people navigate equipment requests, access counselling, book medical appointments, secure employment supports and find housing options they would not have found on their own.

The Chalet Point outcome evaluation found that the majority of pilot participants experienced a meaningful improvement in their quality of life. The things they valued most were straightforward: a worker who listened, followed through, and respected their choices; support flexible enough to be used for grocery shopping or a community outing, not just personal care; and the ability to direct their own care rather than fit into a program's rigid schedule.

The SARC research shows that, across Canada, individualized, flexible funding models, where people direct how support is used, lead to better outcomes than rigid, task-list-driven models. Person-centred assessments that use plain language, allow adequate time, and respond to individual circumstances are associated with better access and better results.

The IAS pilot provided the same services that exist in Manitoba today, but delivered them differently: with more flexibility, more coordination, and more genuine attention to what each person actually needed. The results were better. This tells us that how support is delivered matters.

Theme 2: The Eligibility Door Is Too Narrow

The most consistent finding across all three bodies of work is that many people with real disability-related needs cannot get into Manitoba's adult disability services system because they do not meet various eligibility criteria.

One of Manitoba's disability support programs, CLDS, currently requires applicants to have an intellectual disability as defined under The Adults Living with an Intellectual Disability Act. In practice, this means an IQ of 70 or below as identified by psychological testing. In addition, the intellectual disability must be present prior to the age of 18. This means that adults with acquired brain injuries, neurological conditions, physical disabilities, chronic illness, or invisible disabilities like severe arthritis or chronic pain may be excluded from a given program, even when their functional needs are significant and documented by a doctor.

The IAS team encountered this barrier directly. Most IAS pilot participants did not meet the eligibility criteria for CLDS. The team navigated around this by providing services based on functional need rather than formal eligibility, and by working within the pilot's mandate. While these workarounds helped pilot participants, this was not a scalable model for use outside of the pilot.

Chalet Point heard this theme from several perspectives: from the 210 people who took part in community engagement sessions, from pilot participants in individual interviews, and from family members. People described being turned away despite documented medical need, being unable to access services that had been available to them as children, and being told that because they had learned to cope or had managed to hold a part-time job, they did not qualify. Some described the eligibility process itself as humiliating.

All three bodies of work identify limitations in the current eligibility criteria for Manitoba's adult disability services, including the exclusion of some adults with documented functional needs. The IAS pilot encountered these limitations in practice, community participants described being denied access despite need, and the SARC research documents broader variation in eligibility approaches in other provinces.

Theme 3: Navigation Helps, But It Cannot Solve All Barriers

The IAS team navigated complex systems on behalf of 33 people during the pilot. They found workarounds, bent rules where they could, advocated persistently across departments, and found solutions that ordinary caseworkers cannot. For many participants, this made a meaningful difference.

The IAS team also documented, consistently and in detail, where navigation was not enough. Such as:

- Transportation policy changes required Treasury Board authority.
- Equipment requests involved multiple departments without always having a clear lead.
- Home modification funding was available only for seniors and low-income individuals.
- Mental health services were capacity-limited and restricted by eligibility criteria and physical accessibility.
- Housing options were scarce.
- Self-directed care came with an administrative burden that fell largely on individuals and families.

The Creative Solutions section of this report is, in part, a summary of situations where the IAS team hit a wall that neither exceptions to rules nor creativity could solve. The community-proposed creative solutions were, in their view, practical, targeted ideas grounded in participants' actual needs. Many of them were not implemented because they required policy changes, funding increases, or cross-departmental authority that were interpreted as outside the scope of the pilot.

Although the majority of participants expressed that the pilot improved their lives, a few pilot participants said the pilot made no difference for them, because their barriers were structural, not navigational.

The SARC research shared evidence from across Canada that shows that better service coordination reduces fragmentation and improves access, but only up to a point. Eligibility barriers, inadequate income supports, housing shortages, and rural service gaps require policy and funding responses, not just better navigation. The IAS pilot demonstrated that Manitoba's system can work better — but it also showed that the system itself needs to change.

Theme 4: Program Boundaries Create Gaps in Access to Services

Manitoba's disability services system is built around distinct programs with distinct eligibility criteria, distinct funding streams, and distinct departmental mandates. For people whose needs span those boundaries, the result is often that they do not fit anywhere.

IAS participants' needs crossed the boundary between the WRHA (which funds home care and health services) and Manitoba Families (which funds CLDS, EIA and MSPD). The two departments operate under different policies, different funding models, and different eligibility frameworks. Coordinating between them required constant effort from the IAS team. At times, even with two coordinators working on it, access to services was delayed, disrupted, or denied because of inter-departmental complexity.

This coordination challenge shows up across every thematic area of the Creative Solutions section. For example:

- Equipment funding exists across the Disability and Health Supports Unit with Manitoba Families and WRHA Home Care, with no single point of access, approval and accountability.
- Mental health services are largely unavailable to people who do not meet WRHA Community Mental Health's high priority threshold.
- Clinical supports like physiotherapy are difficult to access and fund.

CLDS-funded agencies faced some challenges to meet the needs of different populations such as those with physical disabilities or complex medical conditions. The SARC research found that across Canada, the fragmentation of income supports, home care, equipment, and community services is a recurring and well-documented problem. Programs operate in silos. People who do not fit one program's criteria fall through to the next — and often find that does not fit either.

Chalet Point's outcome evaluation gave this pattern a name that one participant coined: "living in the gap." This describes the experience of people who work part-time — enough to disqualify them from income-tested programs, but far too little to cover the real costs of living with a disability. The same dynamic applies across other program boundaries: not disabled enough for one program, not the right kind of disability for another, not in the right geography, not the right age.

Theme 5: Housing Barriers Without a Solution

Housing came up frequently in the IAS team's daily case work, in the community engagement sessions, in the individual outcome interviews, and in the research literature. It is the theme that all three bodies of work identify as unresolved.

The IAS team worked with nine participants on housing-related needs. Their options were limited. There is no dedicated home modification program for working-age adults with disabilities in Manitoba. The programs that do exist, such as the Safe and Healthy Home for Seniors Program and the Residential Adaptations for Disabilities Program, are targeted at seniors or low-income homeowners and exclude many people in the pilot. Two participants paid for home modifications out of their pockets. One participant required an accessible community placement that was only secured through an exceptional arrangement under a hospital contract. Accessible community housing is in short supply, and for some participants, hospital discharge was delayed because appropriate placement had not yet been identified or available.

SARC's research work drew on an international review of 60 studies across 18 countries. It found that accessible housing is consistently associated with greater independence, better physical and mental health, improved safety, and greater community participation. The research recommends legislating accessibility in new buildings, funding home modifications, and supporting people with navigating accessible housing options. The conclusion of the international evidence is that accessible housing is not a luxury — it is a health and human rights issue.

Chalet Point heard from many people who participated in engagement or evaluation that housing is a concern. Group homes and personal care homes were described as cramped and institutional. People said they were forced into personal care homes not because they needed that level of care, but because there was no accessible alternative. Young adults moving from family homes into independent living found their new housing less accessible, not more. People in rural Manitoba described inaccessible rental housing and no options for funding modifications. Some raised concerns about the barriers that linking housing and disability related supports together can create.

All three bodies of work arrive at the same point: housing cannot be addressed through better navigation or creative workarounds within the current system. It requires investment, policy change, and a dedicated focus on accessible, affordable housing for people with disabilities.

Theme 6: Where You Live Determines the Support You Get

The IAS pilot encompassed the Winnipeg Health Region only despite advocacy and formal requests to conduct it Manitoba wide. The community engagement that Chalet Point conducted reached beyond Winnipeg, to Brandon, Dauphin, Thompson, and Steinbach, and what it found was consistent: outside of Winnipeg, the gaps in disability services are significantly larger.

Transportation was among the most significant barrier documented by the IAS team for pilot participants in Winnipeg, even though these are participants in the most service-rich part of the province. Twenty out of 30 participants experienced issues with transportation. The IAS team helped six participants access transportation solutions, but many community-proposed creative solutions around transportation, such as increasing transportation funding amounts or giving the IAS team authority to approve additional transportation supports, could not be implemented because they required changes to EIA policy or Treasury Board approval.

Engagement participants from rural and northern communities described travelling six to eight hours round-trip to Winnipeg for physiotherapy, wheelchair repair, specialist appointments, and other services that are routinely unavailable locally. They described public transportation options that are inaccessible, unaffordable, or simply absent. They also mentioned disability services organizations that are under-resourced and under-staffed, and that have no representation in provincial funding discussions.

The SARC research examined rural service delivery models across Canada and found that hub-and-spoke regional networks, mobile services, and telehealth and virtual care models can reduce travel burden and improve access, but only when they are adequately resourced and when broadband infrastructure supports them. On rural staffing, SARC found that single strategies do not work. Retention of disability support workers and nurses in rural areas requires combinations of financial incentives, wage improvements, training, mentorship, and working condition improvements. Disability support worker recruitment and retention, SARC notes, is consistently under-prioritized compared to nursing.

The geographic inequality in Manitoba's disability services system is not a new problem. The pilot and the engagement confirmed its scale and its human cost. A new disability support system must work for people in Churchill, Elie, Steinbach, Russell and everywhere in between.

Theme 7: Families and Workers Are Essential to the System

Two groups sit at the edges of Manitoba's disability services system and hold much of it up through their own effort: family caregivers, and the disability support workers who provide direct care are under pressure. Both are largely invisible in conversations about system design.

Chalet Point heard from family caregivers across Manitoba, who described taking on primary care for their adult children or family members because formal services were unavailable or unaffordable. Many have been doing this for decades. They described burnout, financial strain, and growing anxiety about what will happen to their loved ones when they can no longer help. Some are managing care plans, scheduling support workers, handling paperwork, and filling gaps in services. Respite services are hard to access. Many participants said they could not hire family members as paid respite workers even when no one else was available. The expectation that families will fill gaps in formal service delivery, engagement participants said, is neither fair nor sustainable.

Within the IAS pilot itself, the administrative burden of self-managed care fell heavily on participants and their families. Managing Self and Family Managed Care (SFMC) funding involved hiring and scheduling workers, handling payroll, and reporting to government. The IAS team tried to ease these responsibilities but could not fully resolve within the IAS pilot's scope.

The SARC research found that consumer-directed caregiver support programs are associated with better mental health outcomes for caregivers, reduced unmet needs, and lower out-of-pocket expenses. However, formal transition planning programs are almost entirely absent across Canada.

Engagement participants identified that the disability support sector is experiencing a staffing crisis that affects everyone in the system. They described inadequate pay, high turnover, insufficient training, and workers who are increasingly asked to manage more complex care with fewer resources. IAS pilot participants described the trauma of having to explain their disability and their needs to a new worker, again, because their previous worker had left.

The SARC research found that strategies such as combining wage improvements, training, mentorship, and working condition changes are more effective than any single intervention. It also found that disability support worker recruitment and retention receive significantly less policy attention than nursing, despite being just as essential to people's ability to live in community.

Both family caregivers and disability support workers are essential to the system. Manitoba's adult disability services system relies substantially on informal and semi formal labour provided by family caregivers and direct support workers to bridge gaps in formal service provision.

Theme 8: Co-Designing with Community Requires Genuine Power-Sharing

The IAS pilot was built on a commitment to community involvement. People with lived experience were represented on the Steering Committee, and the settlement agreement that created the pilot explicitly called for creative solutions and community engagement. This was meaningful and important to those with lived experience who brought forth the original concerns.

However, what both the Creative Solutions section and the Chalet Point process evaluation document, clearly and consistently, is that representation on a committee is not the same as genuine participation in decision-making. Community representatives on the Steering Committee described a persistent experience of being heard but not listened to; of proposing solutions that were acknowledged, reviewed, and then set aside; of not having access to enough information about participants' actual needs to do their job; and of feeling that real authority, over budgets, over policy, over what the pilot could and could not try, remained elsewhere with government. Government representatives were not wrong that privacy legislation limited information-sharing. They were not wrong that Treasury Board authority sat above the Steering Committee. These are real constraints. However, the Terms of Reference for the Steering Committee were not clear enough about what community members' roles were. This ambiguity meant that both sides interpreted their responsibilities differently, an issue that was not resolved during the pilot.

The community-proposed creative solutions were submitted in February 2024, after extensive work by community representatives who identified twelve thematic areas where changes were needed. A request for supplemental funding to trial these solutions was submitted in July 2024. It was denied in December 2024. Community representatives understood the pilot as an opportunity to test innovative approaches; government representatives understood it as an opportunity to improve existing ones. This difference in vision shaped the entire pilot.

Any future model of service delivery that involves community governance will need to be designed differently: with clearer terms of reference; explicit agreements about information sharing; genuine decision-making authority shared with community members, not just advisory roles; and consistent expectations from the beginning about what the partnership is trying to achieve.

What These Themes Tell Us Together

The IAS pilot ran for 30 months, served 33 people, and produced tangible results for most of them. The IAS team was skilled, creative, and persistent. The research conducted by SARC identified promising practices from across Canada and internationally. The engagement conducted by Chalet Point gathered the voices of 210 people from across Manitoba who described their lives with clarity and consistency.

All three bodies of work point in the same direction. The themes above represent what the evidence from practice, from research, and from lived experience established. They form the basis for the recommendations that follow.

Recommendations

Core Recommendation

1. Establish a New Disability Support System in Manitoba

The IAS pilot clearly demonstrated the challenges and systemic barriers experienced when accessing adult disability supports in Manitoba.[20] Based on these findings, Manitoba must establish a new, province wide disability support system that is fully compliant with human rights law and principles. Manitoba must create policies, practices and legislation that directly address the systemic issues raised in the Human Rights Complaints brought forward by Tyson Sylvester and Amelia Hampton. There must be no exceptions, including for First Nations living on or off reserve.

The goals of this proposed system reform are to:

1. End the existing alleged discrimination; and
2. Ensure that the alleged discrimination does not reoccur.

The establishment of a new Disability Support System is the foundational recommendation from which all other program reform recommendations flow. All subsequent recommendations describe how this new system must function.

Key terms used throughout these recommendations are defined in the Key Definitions and Principles for Implementation section at the end of the document.

This system should:

- Be grounded in the Manitoba's Human Rights Code, the Canadian Charter of Rights and Freedoms, and the United Nations Convention on the Rights of Persons with Disabilities.
- Provide supports based on need. Supports should not be determined by diagnosis, age, geography, or cause of disability.
- Be designed, governed, and held accountable through the ongoing leadership and lived expertise of people with disabilities, families, and communities.
- Operate as a whole of government responsibility, with Manitoba accountable for coordination across departments, agencies and Manitoba's health authorities.
- Ensure equitable access for all people, including First Nations people living on reserve and off reserve, and people living in rural, remote, and northern communities.
- Be transparent and accountable in decision-making, service delivery, and measurement of outcomes, with accountability supported by independent oversight.Be easy to navigate and flexible enough to respond to individual needs, life circumstances, and changing goals.
- Provide supports that are culturally safe, respectful, and reflective of people's identities, languages, values and community connections.

20 Throughout the section, "Manitoba" refers to the Manitoba government as a whole, including all relevant departments, agencies, and Crown entities.

- Be supported by stable, ongoing, and secure funding that is sufficient to meet community needs and ensures continuity of supports over time.

Immediate Recommended Changes During Transition

The following changes should be implemented immediately to prevent harm during the transition to the new system.

Home Care

Manitoba should immediately amend Home Care policies to remove restrictions that prevent people with disabilities from living full, community-based lives. This includes:

a) Manitoba should immediately eliminate the restriction that limits the use of Home Care supports to inside a person's home. Home Care hours should be usable in community settings when required to support daily living, health, safety, participation, and inclusion.
b) Manitoba should ensure Home Care assessments, eligibility, and service delivery address both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) (See Key Definitions). Supports should include, but not be limited to, personal care, medication support, meal preparation, shopping, transportation support, money management, communication support, and assistance to participate in community life.
c) Manitoba should eliminate caps on Home Care hours and replace them with needs-based service allocation. The amount of Home Care provided should be based on what the person needs to live safely and with dignity, not on predetermined time limits or program ceilings.
d) Manitoba should immediately remove policy exclusions that restrict access to Home Care for First Nations people. First Nations individuals should have equitable access to Home Care services on-reserve and off-reserve, without delay, denial, or jurisdictional barriers

Community Living disABILITY Services (CLDS)

a) Manitoba should immediately suspend the use of IQ-based eligibility thresholds and practices within CLDS. Eligibility decisions during the transition should be based on functional needs and support requirements, not IQ scores or diagnostic labels.
b) Manitoba should ensure that adults with disabilities who do not meet current CLDS eligibility criteria—but who have significant functional support needs—are not denied services during the transition period. Interim access to supports through CLDS should be provided while the new needs-based system is implemented.
c) Manitoba should prohibit service denials, reductions, or delays based solely on policy barriers that restrict access during the transition. Where needs are identified, Manitoba should provide supports first and resolve program responsibility administratively.
d) Manitoba should ensure that CLDS-funded supports address both ADLs and IADLs, including community participation, decision-making support, and daily life management—not only personal care or supervision.

Transition Planning

a) During the transition from current programs to the new needs-based system:
    - No person currently receiving disability supports may have supports reduced, delayed, or discontinued due to system changes.
    - Interim access should be provided for people who meet needs criteria but do not yet qualify under the new system; and

b) Manitoba should ensure that people currently waiting for services and supports do not have to reapply or restart the process under the new system, and that their place in line is maintained. Manitoba should allocate sufficient and sustained funding for implementation, recognizing that person-centred, coordinated service delivery requires adequate staffing, training, and technology investment.

These interim changes should remain in effect until the new needs-based eligibility system is fully implemented and operational.

System Design Recommendations

2. Needs Based Eligibility and Access

2.1 Replace Diagnosis Based Eligibility with Needs Based Eligibility

a) Manitoba should replace diagnosis driven or IQ based eligibility criteria, such as Home Care and Community Living disABILITY Services, with a functional, needs based eligibility system that focuses on the supports a person requires to live safely, independently, and with dignity in the community. Needs-based eligibility should assess both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), including the supports required to manage daily life, maintain housing, access the community, and participate in society. This eligibility framework should recognize disability as the interaction between a person and their environment.
b) Manitoba should eliminate diagnostic exclusions, including for people with brain injury, autism, Fetal Alcohol Spectrum Disorder (FASD), mental health related disabilities, and other cognitive disabilities.
c) Manitoba should create one eligibility determination process that is recognized across all disability related programs. This needs assessment process should be co designed with people with lived experience of disability and made available at no cost, ensuring that individuals are not excluded due to an inability to afford eligibility assessments.
d) Manitoba should ensure that eligibility automatically connects people to relevant supports, including income supports.
e) Manitoba should ensure that once a person is found eligible, they are not required to repeatedly prove their disability or need for supports. The system should be flexible and responsive, allowing supports to change over time as a person's needs, goals, or circumstances change, without triggering unnecessary reassessments. Needs assessments should include both daily personal supports (ADLs) and the supports required to live independently in the community (IADLs).
f) Manitoba should establish clear timelines for eligibility determinations and prohibit indefinite waiting lists once need is established.

g) Manitoba should ensure there is an appeal process that provides an independent, timely, and accessible mechanism for individuals to challenge eligibility decisions, service denials, delays, or reductions. Timely means within timeframes that prevent harm, loss of housing, or interruption or delay of essential supports. Decisions are binding and remedies should be implemented without delay.
h) Manitoba should design the eligibility framework to ensure there are no eligibility exclusions for First Nations people living on reserve.
i) Manitoba should ensure that needs assessments are conducted using clear, plain language; that people are given advance information about the purpose and process of assessment in accessible formats (audio, large print, braille, electronic); and that individuals have adequate time, support, and choice about who participates in the assessment. Assessment processes should be:
    - Flexible and person-led, not constrained by predetermined forms or categories
    - Responsive to individual communication needs and preferences (including use of interpreters, facilitators, or technology)
    - Conducted over multiple meetings if needed, at times/locations convenient to the person
    - Trauma-informed, recognizing that disclosure of disability-related experiences may be difficult
    - Not used as justification for mandatory diagnostic testing or assessments beyond what is needed to determine supports
    - Subject to the appeal mechanism outlined in 2.1(g)

j) Manitoba should establish a maximum timeline for needs assessments (30 days) and prohibit indefinite waiting or "further assessment needed" delays when need is clearly established.

2.2 Ensure Continuity of Supports Across the Lifespan

a) Manitoba should create a system that ensures continuity of disability supports across the lifespan, eliminating disruptive transitions at ages 18–21 and 65.
b) Manitoba should ensure the system provides for a seamless transition from youth to adult services and from adult to senior systems with continuity of needed health, income, equipment, housing, respite, and transportation supports.
c) Manitoba should create and maintain a provincial transition policy that sets timelines, roles, and accountability so that disability supports are not interrupted or changed when people reach a certain age.

3. One Door Navigation and Cross Department Coordination

3.1 One Door Navigation and Cross Department Coordination

a) Manitoba should establish a province wide, one door navigation system so people with disabilities do not need to understand or navigate government structures to access supports, including supports required for daily living and community participation. The new system should function as a single, coordinated entry point across all relevant departments, with the authority to coordinate and approve supports.
b) Manitoba should implement and maintain caseload targets that enable relationship based navigation and support rather than purely crisis management. Navigators should be structurally independent from eligibility denial or budget control to ensure they can advocate for the person's needs without conflict of interest. Services will be delivered by community organizations where this improves trust and accountability.
c) Manitoba should require all relevant departments (including Health, Families, Education, Housing, Justice, and Income Supports) and provincial health authorities to participate in shared, person led planning, including planning for supports that help people manage daily life, keep their housing, and participate in their communities. A shared information system should allow navigators, with consent, to coordinate cross departmental supports. Navigators would help people be aware of options that would meet their needs, assist with making applications, and advocate for access and services.
d) Manitoba should ensure the one door system has authority to resolve interdepartmental disputes, so individuals are not left without supports due to internal jurisdictional disagreement.
e) Manitoba should require all departments to comply with decisions made through the one door system and may not refuse or delay supports due to internal jurisdictional boundaries.
f) Manitoba should fund, create, and maintain a publicly accessible, province-wide website that provides clear, comprehensive information on all services and supports available to children and adults with disabilities in Manitoba. The website should be written in plain language, searchable, regularly updated, and include detailed, step-by-step information on eligibility, access pathways, timelines, and contact points so people, families, and caregivers can understand what is available and how to access it.
g) Manitoba should provide navigation support in ways that are culturally respectful and responsive and where possible provided by trusted community-based or culturally specific organizations.

4. Income and Funding Reform

4.1 Adequate and Dignified Disability Income

a) Manitoba should increase disability income support rates to reflect actual costs of living with disability, with particular attention to costs of:
    - Accessible housing and home modifications
    - Transportation and mobility aids
    - Assistive technology and equipment
    - Specialized diet and health-related expenses
    - Attendant care beyond what government programs cover

b) Establish an indexed disability cost-of-living supplement, co-developed with community, reviewed annually, to account for rising costs in these areas.
c) Remove work penalties and income verification requirements that create barriers to employment or episodic work for people with disabilities. Income supports should not create barriers to education, training, volunteering, or community involvement.
d) Align Manitoba Supports for Persons with Disabilities (MSPD) automatically with eligibility criteria for all disability services, eliminating need for separate disability impact assessments.
e) Ensure that income support eligibility determinations are timely (completed within 30 days) and that interim financial support is provided while applications are processed.
f) Manitoba should ensure that people with disabilities (accessing EIA and MSPD) who wish to pursue employment or self employment have access to robust, individualized employment supports as an entitlement, not a discretionary benefit. These supports should include education, job development, job coaching, workplace accommodations, assistive technology, transportation, training, and ongoing support to obtain, maintain, or change employment as needs and circumstances evolve.
g) Manitoba should ensure that access to income and disability supports should not be conditional on seeking or maintaining employment.

4.2 Flexible, Person Controlled, Portable Funding

a) Manitoba should create funding mechanisms that ensure that individual budgets are portable. Funding should follow the person across regions, housing settings, or life transitions.
b) Manitoba should increase opportunities for flexible, self directed funding options and provide options where people can get assistance with the administrative burden of directing their services, if needed. In addition, administrative barriers that make self direction difficult should be reduced, including complex paperwork, unclear rules, or inconsistent decision making.
c) Manitoba should ensure that funding is flexible enough to be used for culturally relevant supports, community participation, and meaningful life goals—not only basic needs. This would include supports and expenses related to daily living, managing a household and participating in the community and other individualized supports identified through person led planning.
d) Manitoba should ensure that the system has safeguards so self directed funds are not exploited or used for purchases or supports not intended or needed by the person.

5. Housing and Community Living

5.1 Real Housing Choice

a) Manitoba should move away from institutional and congregate residential support models that limit autonomy, restrict movement, and isolate people from community life.
b) Manitoba should develop a provincial housing strategy for adults with disabilities aligned with domestic and international human rights obligations.
c) Manitoba should increase the supply of accessible, affordable units in the community—including deeply affordable units tied to disability income levels—and provide rent supplements or bridge subsidies so people can afford market rents.
d) Manitoba should establish and fund a comprehensive, needs based home modification program that is available to people with disabilities of all ages, not limited to children and seniors. The program should provide timely access to assessments, funding, and construction for modifications required to support safety, accessibility, and independent living, including ramps, lifts, bathroom and kitchen modifications, structural changes, and environmental controls. Eligibility should be based on functional need rather than age, diagnosis, or housing tenure, and should be coordinated with housing, health, and disability supports so people are not forced to move or enter congregate settings due to inaccessible housing. Timely is defined within clearly defined and publicly reported service standards. (see Key Definitions)
e) Manitoba should establish a modern, cost effective, and portable residential funding model that ensures stability, continuity, and quality of supports. Funding should reflect the actual costs of individualized residential services, follow the person across moves and provider changes, and include predictable transition and stabilization funding so people do not lose their home due to funding delays, policy gaps, or administrative decisions.
f) Manitoba should separate housing from service provision so people can change support providers without losing their home.
g) Manitoba should create individualized housing supports that allow people to live alone, with family, friends, or chosen roommates, without penalties. These supports should be available to all people who require them, including those with complex behavioural or medical needs. Flexible support models (outreach, drop in, on call) should be available to support community based living.
h) Manitoba should establish, fund, and maintain a public, regularly updated database of accessible and supported housing options.
i) Manitoba should ensure that changes to policy, funding, or service models during the implementation phase do not result in people being displaced from their homes or forced into congregate or institutional settings.
j) Manitoba should establish an emergency housing protocol to prevent people with disabilities from entering hospital, congregate, or institutional settings due to housing instability. This protocol should:
    - Identify people at risk of housing loss through the one-door navigation system.
    - Authorize emergency rent subsidies, temporary accommodations, or other housing supports within 24-48 hours.
    - Prevent housing loss during system transitions, funding delays, or policy changes, and
    - Hold clear accountability for response timelines.

6. Workforce and Caregivers Supports

6.1 Disability Support Workforce

a) Manitoba should establish, maintain, and fund a province wide wage and training standard for disability support workers comparable to similar sectors (e.g. health care, educational assistants). This should include competitive wages and benefits; standardized training and credentialing and staffing ratios aligned with support needs.
b) Manitoba should create, maintain, and resource a standardized competency-based training and credentialing strategy that ensures that staff working with people with disabilities have the knowledge and skill to fulfil their responsibilities.
c) Manitoba should invest in ways to bring new people into disability support work and help them stay, including paid training, mentoring, and on-the-job support, especially in rural, northern, and Indigenous communities.

6.2 Family Caregivers & Respite

a) Manitoba should formally recognize family caregivers as essential partners in the disability support system and ensure that family caregiving is supported, sustainable, and never relied upon as a substitute for adequate public services.
b) Manitoba should remove prohibitions on paying family members as caregivers when this is the preference of the person receiving support and when it is appropriate to do so. Clear guidelines and safeguards for paid family caregiving should be in place that protect against exploitation while respecting autonomy and choice.
c) Manitoba should provide support for long-term planning with family caregivers, including future housing, financial planning, and transitions when family caregivers can no longer provide care.
d) Manitoba should establish a permanent, needs-based respite framework that is available as an entitlement once need is established. Respite should not be restricted to short-term supports, crisis situations, or specific diagnostic categories (mental/intellectual disability).
e) Manitoba should guarantee predictable and adequate respite hours based on assessed need, with clear service standards and timelines for decision-making, delivery, and replacement when respite services are disrupted. In addition, administrative barriers that make arranging respite services difficult should be reduced, including complex paperwork, unclear rules or inconsistent decision making.
f) Manitoba should ensure that respite funding aligns with provincial wage and training standards so services can be reliably staffed and accessed in practice, including in rural, remote, and northern communities.
g) Manitoba should ensure that respite decisions, including denials, reductions, or delays, are explicitly subject to the appeal mechanism established under Recommendation 2.1.
h) Manitoba should establish a mandatory, person-centred succession and transition planning process that should begin when the primary family caregiver is 55 years of age, or when life circumstances change (e.g., caregiver develops disability, health decline, or expresses concern about sustainability). This process should:

- Include the person with disabilities, the family caregiver, and professional supporters.
- Explore options including transition to other family members, peer support networks, formalized community connections, or paid support arrangements.
- Be funded as an entitlement with access to counseling, planning facilitation, and potentially respite support to explore options.
- Result in a documented, sustainable plan that is regularly reviewed and updated.
- Include contingency planning should the primary caregiver suddenly become unavailable.
- Be coupled with financial planning support (e.g., registered disability savings plans, future housing options)
- Ensure that the transition planning process for a family caregiver-dependent person does not result in institutional placement or congregate living if community-based options are possible. Where institutional placement is the only option, this should be explicitly documented with reasons and subject to periodic review.

7. Equitable Access to Health and Mental Health Care

a) Manitoba should ensure that health, mental health, and disability supports operate in a coordinated and integrated way within the one-door navigation system. Health and mental health services should be fully accessible to people with disabilities. Disability should never be used as a basis to deny, delay, or redirect care.
b) Manitoba should create guidelines and standards that provide guidance to health care providers related to the provision of services to people with disabilities that prohibit health care service refusals based on disability, including exclusions based on diagnosis, IQ, communication method, perceived complexity, or support needs, and should require reasonable accommodation so people with disabilities can meaningfully access assessment, treatment, discharge planning, and ongoing supports.
c) Manitoba should ensure that failures in health or mental health service access are subject to the appeal mechanism established under Recommendation 2.1.(g)
d) Manitoba should recognize and address the systemic barriers that prevent people with disabilities from accessing timely (as defined in Key Definitions) and appropriate mental health services, including service refusals based on disability, lack of provider training, accessibility barriers, and stigma or assumptions about capacity. Manitoba should require disability competency training for mental health providers and mental health and trauma-informed training for disability service providers. Access to mental health services should be included as a core component of needs assessment, planning, and the one-door navigation system.

8. Equipment

8.1 Timely and Clinically Driven Access to Equipment

a) Manitoba should create a system for equipment assessment, authorization, delivery, and repair that ensures that equipment is provided immediately, without delay due to jurisdictional or interdepartmental funding disputes. Responsibility for cost sharing or reimbursement should be resolved after the individual's needs are met. This system should have clear, provincially enforced service standards for assessment, approval, delivery, repair, and replacement and include an emergency equipment approval process for urgent equipment needs. Manitoba should ensure that needs will be defined to include equipment necessary to facilitate both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) – see Key Definitions
b) Manitoba should ensure that once a person is deemed eligible based on need for disability supports, access to required equipment is automatic and does not require separate eligibility determinations, program applications, or diagnostic thresholds.
c) Manitoba should ensure that clinicians have authority to approve required equipment without unnecessary administrative delay.
d) Manitoba should provide required funding and supports for Manitobans to access needed repairs in all geographic areas including transportation and accommodation costs if necessary.
e) Manitoba should establish minimum accessibility, communication, and service standards for equipment vendors, including expectations for wait times and plain-language communication. See Key Definitions.
f) Manitoba should ensure that equipment decisions, including denials, substitutions, delays, or failure to repair or replace equipment, are explicitly subject to the human rights–based appeal mechanism established under Recommendation 2.1.g

9. Transportation

9.1 Accessible and Adequate Transportation Supports

a) Manitoba should ensure people with disabilities have timely, affordable, and accessible transportation necessary to participate in daily life, including medical care, employment, education, and community activities. This should include collaboration with municipal governments, where necessary. Timely is defined within clearly defined and publicly reported service standards. (see Key Definitions)
b) Manitoba should ensure that transportation funding reflects actual costs, including mileage, escorts, and allowances for rural and northern travel. Rates should be consistent across disability services.
c) Manitoba should ensure that the system provides consistent access across regions, so geography does not determine mobility.
d) Manitoba should establish clear service standards and timelines for approval, scheduling, reliability, and response when transportation services fail or are unavailable.
e) Manitoba should ensure that lack of transportation is never used as a justification for hospitalization, institutional placement, or loss of community living.

f) Manitoba should ensure that transportation decisions, including denials, reductions, delays, or service failures, are explicitly subject to the appeal mechanism established under Recommendation 2.1.g

10. Indigenous Rights and Partnership

10.1 Indigenous Access and Equity

a) Manitoba should immediately remove eligibility exclusions for First Nations living on reserve for Community Living disABILITY Services (CLDS) and ensure that the new system is inclusive of and fully accessible to all Indigenous peoples, including on and off-reserve First Nation peoples. Indigenous children and adults with disabilities should not lose supports at age-based transition points, including at ages 18–21.
b) Manitoba should recognize the distinct rights, histories, cultures, and governance structures of First Nations, Métis, and Inuit peoples. Jurisdictional disputes between provincial, federal, and Indigenous governments — including limitations in the application of Jordan's Principle — should not be used to delay, deny, or disrupt access to essential disability supports.

10.2 Indigenous Partnership

a) Manitoba should invite Indigenous leadership to co-create a provincial strategy related to support and services to Indigenous people with disabilities in Manitoba. This will ensure that the system is created in a way that honours unique cultural needs and Indigenous ways of knowing, caring and supporting people with disabilities.
b) Manitoba should establish clear mechanisms within partnership agreements to address disputes, resolve conflicts, and ensure accountability when commitments are not met.

11. Rural and Northern Equity

a) Manitoba should create a system that provides equitable access to rural and northern Manitobans. The system should provide funding that is reflective of the increased costs of living in rural or northern areas. The system will use interdisciplinary regional service hubs (e.g. Access Centres) along with mobile and virtual services (where appropriate) to ensure that all Manitobans receive supports. Services should prioritize local delivery wherever possible, rather than relying primarily on itinerant services from urban centres.
b) Manitoba should address rural and northern workforce shortages through targeted recruitment, retention, and training strategies.

12. Governance, Accountability, and Oversight

12.1 Provincial Disability Advocate

a) Manitoba should establish an independent Provincial Disability Advocate with statutory authority and long term oversight responsibilities. The advocate will monitor systemic issues, investigate complaints and patterns of service failure, issue public recommendations and hold government accountable for meeting obligations under policy and law. The Advocate will table annual reports in the Legislature.

12.2 Independent Implementation Monitoring

a) Manitoba should fund and maintain an independent implementation monitoring body with the authority, expertise, and mandate to oversee implementation of all recommendations, track progress, identify delays and failures, and publicly hold government accountable for meeting its commitments. Government should be required to publicly respond to the monitoring body's findings within defined timelines and to take corrective action where commitments are not being met. The monitoring body should:
    - be guided by people with disabilities, families, and community organizations, with lived experience playing a central role in defining priorities, indicators, and interpretation of findings.
    - establish clear implementation milestones, performance indicators, and benchmarks, and publicly report progress through accessible dashboards that track timelines, delays, barriers, and corrective actions.

b) The independent implementation monitor is responsible for overseeing implementation during the transition period. Long-term systemic oversight will transition to the Provincial Disability Advocate, and outcome evaluation will be conducted separately through the independent evaluation framework set out in Section 13.

12.3 Five Year Implementation Plan

a) Manitoba should implement these recommendations within five years of receipt of the IAS Pilot Project final report through a fully resourced, phased implementation plan that is co-developed and co-governed with people with disabilities, families, community organizations, and Indigenous partners.
b) Manitoba should establish a clear, publicly available roadmap with defined phases, milestones, and timelines for implementing each recommendation. There should be clearly defined roles, responsibilities, and accountabilities across all participating departments and agencies, and align departmental mandates with the implementation plan. Failure to meet milestones without justification constitutes non-compliance with the Memorandum of Understanding (MOU) and the documented implementation plan.
c) Manitoba should support the implementation with multi-year funding commitments rather than annual or discretionary funding allocations.

d) Manitoba should provide plain language public reporting on implementation progress at regular intervals.
e) Manitoba should ensure that the implementation plan should remain in force across changes in government and be amended only through transparent, public processes.

13. Evaluation, Outcomes, and Continuous Improvement

- a) Manitoba should establish a comprehensive, transparent evaluation framework to measure the implementation and impact of these recommendations and the transformation of the disability support system. The evaluation should be conducted by an independent evaluator, selected jointly by government and the disability community representatives. The evaluator should be selected and in place at the beginning of the implementation period. All evaluation reports should be made public in full and should not be edited or altered by government prior to release. The purpose of evaluation is to:
    - Determine whether the new system is achieving its intended outcomes.
    - Assess whether the system is improving the quality of life and everyday experiences of people with disabilities.
    - Identify gaps, unintended consequences, and areas requiring course correction.
    - Ensure public accountability and sustained learning over time.
    - Measure both system performance (access, timeliness, equity, consistency) and lived outcomes (safety, autonomy, belonging, participation, and well being).
    - Use indicators that reflect what matters to people with disabilities and their families, not only administrative efficiency.
    - Assess equity across geography, age, gender, Indigenous identity, type of disability, and other relevant factors.
    - Collect qualitative and quantitative data, including stories of lived experience, to understand real world impact.
    - Distinguish between service outputs and real-life outcomes, ensuring evaluation focuses on whether suppor s actually improve people's daily lives, not just whether services were delivered.

b) Manitoba should use evaluation findings to make timely adjustments to policy, funding, and practice.
c) Manitoba should use this system transformation to build and share evidence about what works in supporting good lives for people with disabilities, including publishing findings and lessons learned so they can inform future policy and practice in Manitoba and other jurisdictions.

Key Definitions and Principles for Implementation

For the purposes of these recommendations, the following terms are defined:

- Disability: The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) defines disability as an evolving concept resulting from the interaction between persons with physical, mental, intellectual, or sensory impairments and attitudinal/environmental barriers. This interaction may hinder their full and effective participation in society on an equal basis with others.
- Needs-based: Determined by functional support requirements and the person's goals, not diagnosis, IQ score, or arbitrary categories.
- Activities of Daily Living (ADLs) are the basic self care tasks a person needs to do everyday to take care of their own body. E.g. bathing, grooming, eating, going to the bathroom, getting in and out of bed, chair, etc.
- Instrumental Activities of Daily Living (IADLs) are tasks that enable a person to live full lives in the community (e.g. managing finances, coordinating health care, getting around your community, communicating with friends and family, house management, social participation,
- Timely: Within clearly specified service standards that prevent harm, loss of housing, or interruption of essential supports. Timelines vary by urgency (emergency = 24-48 hours; routine = 14 days).
- Indigenous peoples: First Nations, Métis and Inuit peoples.
- First Nations, Métis, and Inuit peoples: Distinct peoples with inherent rights. Services should recognize and reflect unique governance, cultures, and jurisdictions.
- Accessible: Physically accessible (barrier-free environments), communication-accessible (plain language, alternative formats), and culturally accessible (reflective of identities and values).
- Person-centred: Designed, planned, and evaluated from the perspective of the person with lived experience, with their goals and preferences as the starting point.

Looking Ahead: Commitments and Future Direction

The commitments made by the Manitoba government and the Winnipeg Regional Health Authority (WRHA) continue beyond this final report. Consistent with the settlement agreement resulting from Amelia Hampton and Tyson Sylvester's complaints, the Manitoba government and the WRHA will make best efforts to implement the recommendations arising from the IAS pilot. The departments have further committed, as established in the Project Charter, to present a go-forward plan within six months of receiving this report.

Government commitments have also extended to the pilot participants themselves. Prior to the conclusion of the pilot in September 2025, participants received communication from Manitoba Families, Manitoba Health, Seniors and Long-Term Care and the WRHA confirming that supports received during the pilot would continue. This approach acknowledges that the supports provided through the IAS pilot were integral to their ability to live independently and participate fully in their communities.

The IAS pilot has contributed to a better understanding of how Manitoba's disability supports system currently operates, where the challenges and gaps are, and how service adjustments and flexibility can make a difference in individuals' lives. Findings show that when adults with complex disability and medical needs receive flexible, person-centred, and well-coordinated support, outcomes and their overall quality of life improves. At the same time, the barriers and gaps identified through the pilot reflect the discrimination alleged in the original human rights complaints.

The recommendations in this report represent a roadmap for systemic change. The forthcoming government response to these recommendations will guide how Manitoba's disability supports system continues to evolve and inform ongoing efforts to strengthen service delivery. The collective work reflected in this final report advances a future where all Manitobans with disabilities have access to the services and supports they need to live with equality, dignity, and respect.