Shared health Soins communs Manitoba

Manitoba's Clinical & Preventive Services Plan

Investing in Better Care, Closer to Home

CHRONIC AND COMPLEX MEDICINE
PROVINCIAL CLINICAL TEAM

Clinical & Preventive Services Plan Summary

An opportunity to elevate outcomes through reconfiguration

Manitoba's key population characteristics create an opportunity for the province's health system to both **meet evolving needs and set the standard for care in priority areas including rural health, healthy aging, and needs of diverse populations.** The significant **Indigenous population** presents an opportunity for leadership in **collaborative design and delivery of health services**.

Key Population Characteristics

Manitoba's Population is Growing

Growth rates vary by region with **higher growth in Winnipeg and Southern regions**, by 45% and 62% respectively, over the next 25 years.

Manitoba is Highly Rural

44% of the population is **highly distributed across geographies** with less than 10 people per km

Manitoba has an Aging Population

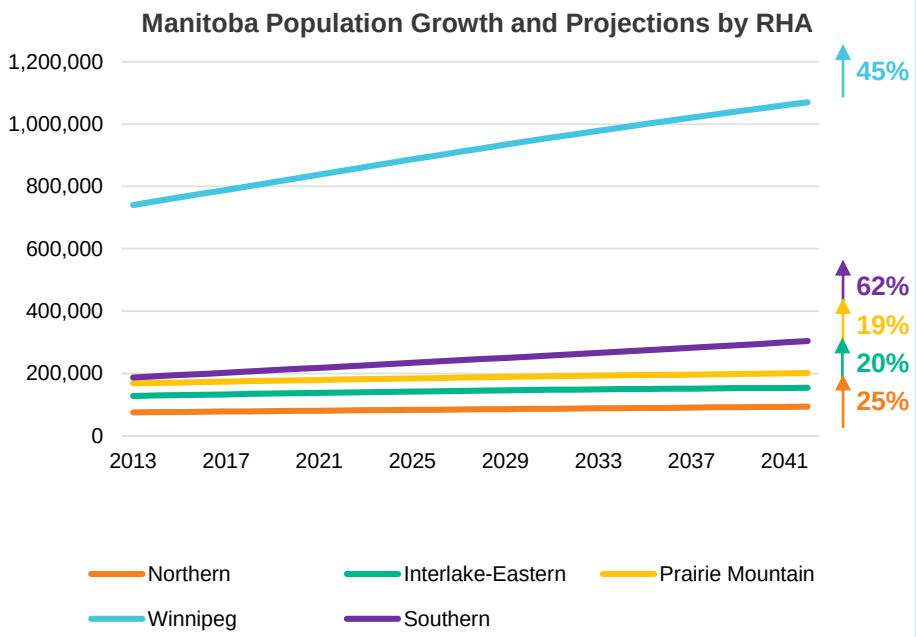
The **largest growth** is projected to occur with the **80+ and 60-70 year old cohorts** however Manitoba remains the only province where youth under 15 exceed the older population

Manitoba has a large Indigenous population

Manitoba's Indigenous population makes up **18% of the population**, the highest of any province in Canada. This population is also younger than the rest of the province

Manitoba has a Diverse Culture

109,925 Manitobans speak French of whom 74% were born in Manitoba. **18.3% of Manitoba's population are immigrants** with 80% settling in Winnipeg



A strong foundation to build upon

Manitoba already holds **capabilities and characteristics** that can be leveraged to enhance the future healthcare system

One provincial academic hospital

The majority of tertiary health services for Manitoba's 1.3M people are delivered in Winnipeg through one provincial academic hospital: Health Sciences Centre (HSC), an internationally recognized and accredited academic hospital and research centre.

A leading university and research centre

University of Manitoba is a leading centre for the training of health professionals and support for specialist care delivery and rural and urban primary care.

International leadership role in the health of First Nations, Metis, Inuit, and Indigenous Communities

- Leadership role in instituting Jordan's Principle – a Child-First Initiative to assure equitable access to essential care
- Internationally recognized partnership-based health research through Ongomiizwin - Indigenous Institute of Health and Healing

Adaptability to innovative models of care

37% Increase in MBTelehealth utilization over in the past five years and multiple modes in place

1m+ miles saved — By clients who visited the Mobile Clinic (primary care bus) over five years in Prairie Mountain Health

Multiple achievements to improve wait times and patient experience

25% Improvement in total time spent in Winnipeg EDs (Winnipeg) – the most improved in Canada

50% Improvement in total wait time for endoscopy through centralized referral and intake models – similar models in place for hip and knee replacements, spine surgeries, and others

Flexible workforce options provide new opportunities to build future models of care

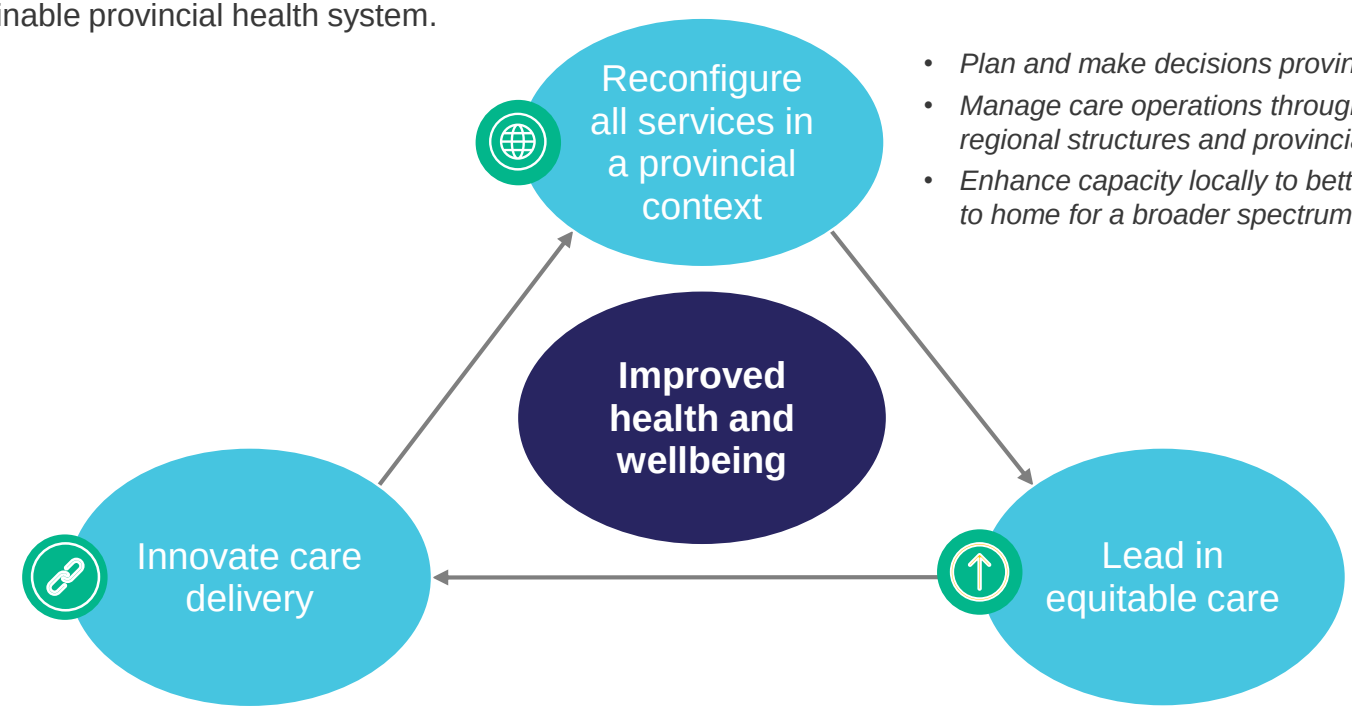
2x More paramedics per 100,000 residents than the Canadian average and more female paramedics (national average: 32%)

20+ Regulated health professions under one umbrella act (*The Regulated Health Professions Act*) with 21 categories of reserved acts

Expanding scope of Nurse Practitioners (e.g., minor invasive procedures, ordering diagnostic tests). Long standing leader in training, education, and employment of physician assistants including into primary care.

Manitoba's bold new future: Reconfiguring For Better Health and Wellbeing

The **elements of the future vision will work together** to improve how the health system supports Manitobans. Through redefined access and service capabilities across the province, Manitobans will benefit from improved health outcomes and a more sustainable provincial health system.



- *Plan and make decisions provincially*
- *Manage care operations through a combination of regional structures and provincial services*
- *Enhance capacity locally to better support care close to home for a broader spectrum of health needs*

- *Provincial clinical governance to support clinical practice and model-of-care improvements province-wide*
- *Modernize care delivery approaches to increase reach and access from a patient and provider perspective*
- *Innovate* how *care is delivered to achieve better health and broader outcomes*

- *Lead in equitable care to urban, rural and remote communities through connected care*
- *Commit to a new future for Indigenous health in Manitoba based on a collaborative model of co-design and enablement among Indigenous communities and the provincial health system*

What does a modernized health system mean for individuals?

TODAY

- **Knowing where to go for the right care can be confusing** – for patients and for providers
- Your health care provider **may not have all the necessary information** about you and your health – this can result in you having to tell your story over, and over, and over again
- You may wait a **long time to access** the right care including diagnostic services and specialist care
- The care you need may not be accessible close to home, **requiring you to travel** to access services
- Your **visits may not be coordinated** across care providers, resulting in multiple trips to access care

IN THE FUTURE

- Consistent, reliable services will be accessible at facilities that are clearly defined by the care they provide, making it **easier to know where to go for care**
- Your health care providers will have **access to appropriate information** about you and your health needs
- Providers will **work together to coordinate** your care, ensuring that wherever you go, you are able to access the right care
- Coordination will **reduce your wait times** and unnecessary travel
- You will have the choice to **manage and navigate your own care**, in partnership with your primary care provider
- Your primary health team will have support to provide your **care closer to home** through virtual tools, advice and guidance

What does a modernized health system mean for individuals?

TODAY

Find a family doctor (primary care provider)
Wait for appointment to discuss your care needs
– or visit an Emergency Department

1st primary care visit

Specialist or diagnostic services referral and wait

Travel for care

1st specialist or diagnostic service visit

2nd primary care visit

Specialist or diagnostic services referral and wait

Travel for care

2nd specialist or diagnostic service visit

3rd primary care visit

Repeat referral and wait until an answer or diagnosis is determined

Travel for care

Ongoing visits to specialists and for tests

IN THE FUTURE

Providers work together to coordinate your care and multiple tools and options exist to help manage your own care

1st primary care team visit (providers with different skills work together)

You have tools to manage your health

You can get advice virtually

You have help to find the right health care

Your primary health team has the information they need about you and your health **and** has access to …

… advice and guidance for more specialized care needs that they can manage, with some support

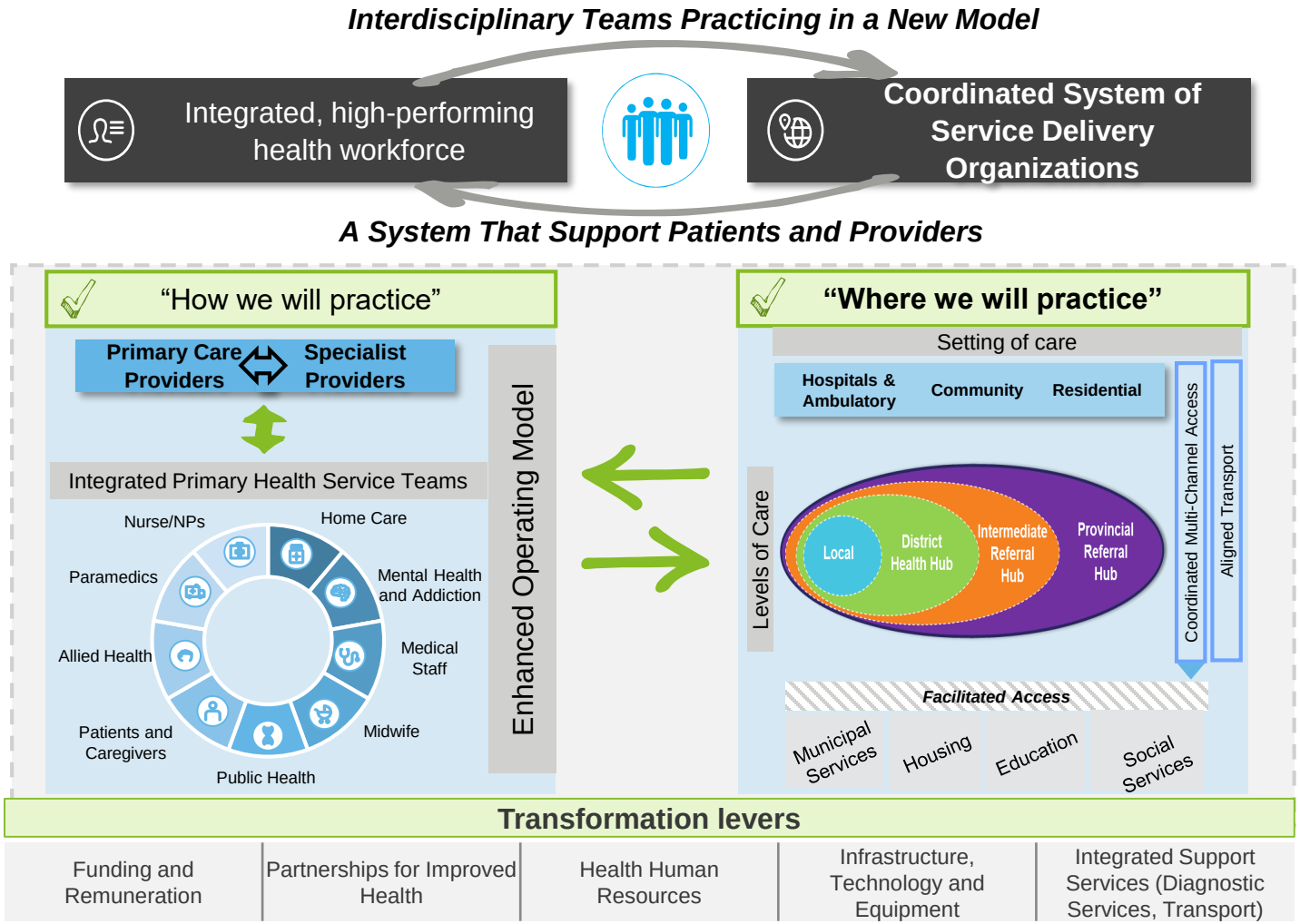
… virtual tools to bring care closer to home

… a network of other teams nearby for in-person or virtual access to care

… coordinated access to specialists that work together to reduce or eliminate unnecessary travel and coordinate with your primary care team

Each step in your care path seamlessly connects back to your local primary health team, keeping them up to date on your care

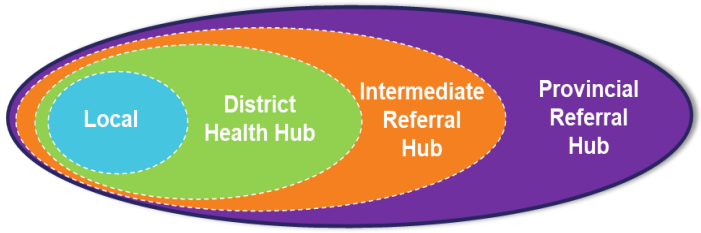
An integrated network for accessing and delivering services is core to the new provincial model



Defining one provincial system with enhanced local capacity and effective access to specialized care province-wide

The Integrated Network Model

- The Integrated Network Model shown below links local, district, intermediate, and provincial hubs and provides common service standards, capabilities and pathways for patients, providers and health system managers in the province.
- The model will reconfigure care to improve the health and well-being of all Manitobans through provincial standards that elevate care and innovative approaches to ensure equitable care delivery. The key to success will be the development of ***appropriate, sustainable*** capacity at the local level and ***standardized pathways*** that streamline how patients and providers navigate the system. ***Provincial clinical governance*** will guide the development and monitoring of standards and pathways. By leading in ***connected care***, Manitoba will optimize a hybrid digital and in-person care experience for everyone.
- The network model is intended to facilitate the relationship between providers and the flow of patients in the province. It is not intended to create barriers or "gates" in the system, instead it will be used to **create transparency and certainty of capabilities**.

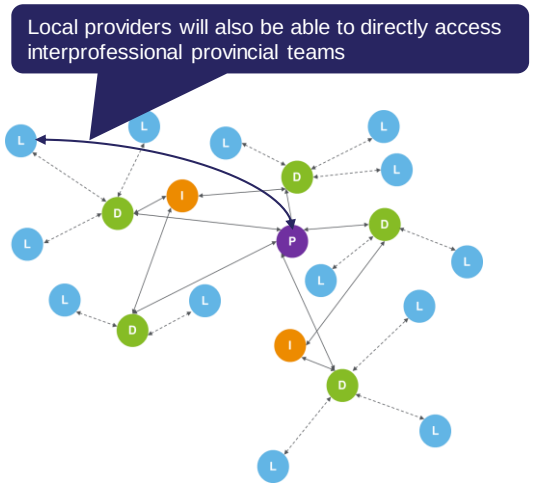


L **Local Area Hub**
Integrated network for prevention and screening, transitional care, community based support and rehab, and primary and community care

D **District Health Hub**
Integrated network for low-moderate acuity, variable volume general medicine/surgery interventions/procedures, post acute treatment and emergency services

I **Intermediate Referral Hub**
Integrated network for moderate acuity/complexity medicine, surgery, critical care, and emergency services

P **Provincial Referral Hub**
Provincial integrated network for high-acuity, highly complex medicine, surgery, critical care, and emergency services



Capabilities across local area hubs will be standardized along a spectrum, with flexibility to meet with population needs

The network model outlines ***minimum service standards and capabilities*** as the basis for infrastructure, health human resources, and clinical support services planning. Local Area and District hubs will feature a spectrum of capabilities (Enhanced, Core) to match the needs of its population, with increased acuity along the continuum from District to Provincial. Facilities at the District and Intermediate level may have targeted areas of programmatic focus that extend into higher levels of care.

Local	District	Intermediate	Provincial
Low acuity community-based care	*Low to moderate acuity community-based and inpatient care*	*Moderate to high acuity inpatient and medical/surgical care*	*High acuity/specialty medical and surgical care*

Enhanced

Interdisciplinary primary care teams who provide enhanced community services such as mental health support, midwifery, chronic disease management, and/or pain management; supported by appropriate diagnostics and the ability for short-term patient observation

Increased focus on **prevention and screening** with proactive population health management capacity

- My Health Teams, new care models (e.g., collaborative emergency centres in Nova Scotia, advanced care centres in Australia)

Core

Local primary care providers will be the main point of contact with the health system for most patients (e.g., Home Clinics)

Increased focus on **prevention and screening** with proactive population health management capacity

Core:
Urgent care during set hours for lower acuity patients

Enhanced and Intermediate:
24/7 Emergency Department

Provincial:
24/7 Emergency Department

General inpatient and ambulatory care with observation and monitoring capabilities, as well as targeted services

Enhanced:
Special Care Unit

Intermediate:
Intensive Care Unit (ICU)

Provincial:
ICU with specialized capabilities

Core:
Elective surgery, primarily with Family Practice Anaesthesia (FPA)

Enhanced and Intermediate:
Elective and emergency surgery with FPA or FRCPC

Provincial:
Elective and emergency surgery with FRCPC

Specialist Services may include:
District: Level I Nursery, community cancer care, primary stroke centre, and/or select areas of programmatic focus

Intermediate:
Level II Nursery, radiation therapy, general rehabilitation, moderate- to high-risk obstetrics and/or primary stroke centre

Provincial:
Intensive rehabilitation, and specialized mental health services, high-risk obstetrics and neonatal

Provincial Services such as:
Major trauma, thoracic services, comprehensive stroke care, specialty cancer care

Creating the capacity for a provincial approach to delivery in Manitoba through a 10-Point Plan

This 10-Point Plan outlines key mechanisms for Manitoba to improve access to care across the province and deliver on the benefits of moving to a provincial approach to care design and delivery

Interdisciplinary Teams Practicing in a New Model

Integrated, High-Performing Health Workforce

Coordinated System of Service Delivery Organizations

A System That Support Patients and Providers

"How we will practice"	"Where we will practice"
1. Provincial clinical governance	2. Clear roles and capabilities in network model
3. Enhanced community supports	4. Innovative approaches to care through digital health
5. Bridge the gap between primary care provider and specialist	6. Consistent pathways for targeted patient populations
7. Shift care between disciplines to enable clinicians to work to full scope of practice	8. Coordinated provincial access
9. Provincializing key aspects of our workforce	10. Provincial approach to outcomes and deliverables management

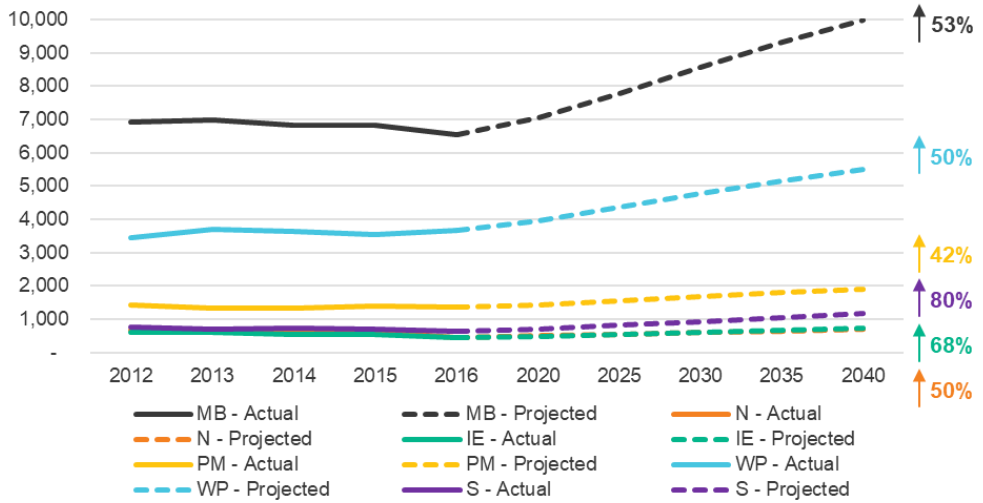
Chronic and Complex Medicine

Current state and case for change

Inpatient admissions, day surgeries and procedures related to Chronic and Complex Medicine expected to increase between 2016/17 and 2040/41

Chronic and Complex Medicine **inpatient admissions** are expected to increase **53%** in the province in the next 20 years

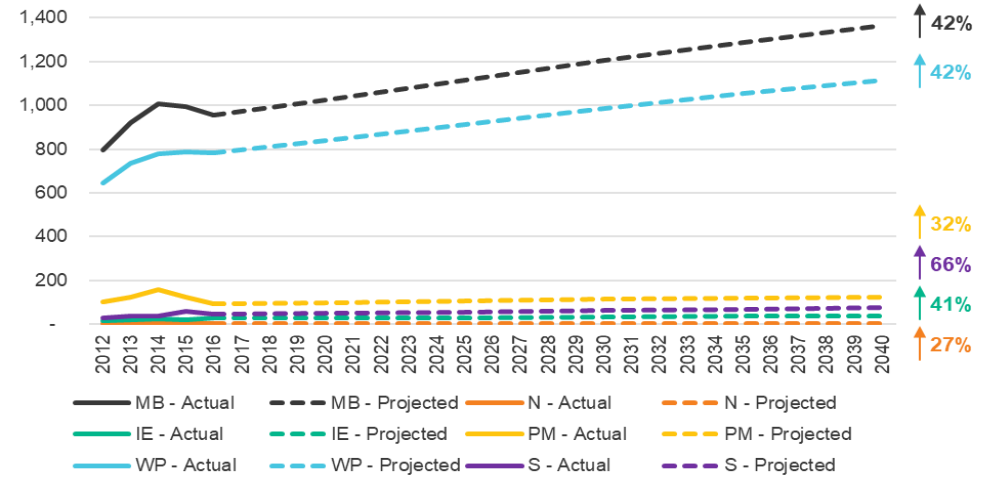
Projected Growth in Chronic and Complex Medicine Inpatient Admissions, FY12/13 to FY40/41



Growth % are Projected between FY16/17 and FY2040/41

Chronic and Complex Medicine **day surgery and intervention/procedure visits** are expected to increase **43%** in the province in the next 20 years

Projected Growth in Chronic and Complex Medicine Day Surgery And Intervention/Procedure Visits, FY12/13 to FY40/41



Growth % are Projected between FY16/17 and FY2040/41

Source: MHSAL – Discharge Abstract Database

Current state and case for change

There are three predominant patient population types in the Chronic & Complex Medicine area: patients with high impact, low volume conditions; prevention oriented, high volume disease patients; and patients with multiple chronic diseases/comorbidities. Major current state issues and supporting evidence indicate the need for change and shifts within this clinical area

Manitoba has existing initiatives and programs to build upon

- **The Manitoba Renal Program** is made up of an **inter-professional team** of health care professionals working together to provide the highest quality kidney care and kidney education. A total of 5,272 patients are in the program as of 2018 and currently, 24% of the patients receiving home dialysis and in-centre dialysis, with 5% on **home hemodialysis which is on par with other jurisdictions** (i.e., Ontario and British Columbia) across Canada.
- The **Diabetes Collaborative Care Pathway** described the patient journey and identified interactions between key stakeholders. As a result, the WRHA developed the **"Diabetes System of Care" strategy** that identifies service gaps and improves linkages to resources, e.g., working with **Pediatric Endocrinology**, two **primary care sites** and **Indigenous agencies on process for approaching youth with diabetes** differently in primary care; **Insulin Mentorship Program**.
- **COPD System of Care** from **upstream identification** through spirometry testing by building up community capacity to screen to INSPIRED **hospital to home model of care** for patients with moderate to severe COPD
- HSC has a provincial **Multiple Sclerosis Clinic** that evaluates, treats, and educates patients newly diagnosed with MS within five weeks and also follows up with patients who have been discharged, previously diagnosed, and patients suffering from acute relapses

Total Hemodialysis Treatments by Region, FY14/15-FY17/18

	2014	2015	2016	2017
Manitoba	**181,560**	**183,021**	**197,183**	**199,796**
Northern	9,312	6,179	8,910	5,653
Interlake-Eastern	11,139	11,563	12,038	13,249
Prairie Mountain	17,542	17,220	20,854	21,492
Winnipeg	13,5742	139,821	146,694	150,514
Southern	7,825	8,238	8,687	8,888

Source: MHSAL - MIS Data

Current state and case for change

There are three predominant patient population types in the Chronic and Complex Medicine area: patients with high impact, low volume conditions; prevention oriented, high volume disease patients; and patients with multiple chronic diseases/comorbidities. Major current state issues and supporting evidence indicate the need for change and shifts within this clinical area

Chronic disease prevalence is growing and highly varied across regions

- In 2015/16, over half of Manitobans aged 40 and older had one or more of the following chronic conditions: diabetes, hypertension, ischemic heart disease, heart failure or chronic obstructive pulmonary disease
- Provincially, 9% of Manitobans had a diagnosis of diabetes:
  - Among all regions except NRHA the diabetes rate ranged between 7% and 10%; in NRHA 18% of the population had diabetes

Prevalence of Chronic Disease by Region, 2015/16

	Chronic Conditions*	Diabetes	COPD
Manitoba	**54.4%**	**9.1%**	**12.6%**
NRHA	66.7%	18.4%	15.6%
IERHA	56.3%	10.0%	13.5%
PMH	54.2%	9.5%	13.0%
WRHA	54.2%	8.6%	12.8%
SHSS	50.8%	7.1%	10.1%

Source: MHSAL – Annual Statistics
* Chronic Conditions includes: diabetes, hypertension, ischemic heart disease, heart failure, stroke, or COPD

Specialized care for patients is challenging to access for patients in rural, remote, and Northern regions and Indigenous populations

- 40% and 42% of patients from Northern and Interlake-Eastern, respectively, receive care for inpatient admissions in Winnipeg
- There is no provincial standard or service for primary health providers to receive timely access to specialists
- Variable capacity and means within local communities for management of chronic diseases including poor local support exists for self-management in Northern and rural communities

Where patient was admitted and treated

Patient's Home Region	Home Region	Winnipeg	Other Non-Winnipeg Region
Northern	59%	40%	1%
Interlake-Eastern	57%	42%	2%
Prairie Mountain	88%	11%	1%
Winnipeg	97%	--	3%
Southern	64%	33%	3%

Source: MHSAL – Discharge Abstract Database

Current state and case for change

PCT members identified duplication and gaps between federal and provincial chronic disease programs.

FEDERAL PROGRAMS FOR FIRST NATIONS	MANITOBA PROGRAMS
• Canada Prenatal Nutrition Program • Aboriginal Diabetes Initiative • YSP – Youth Summer Program • National Native Alcohol and Drug Abuse Program • Public Health • Home and Community Care – First Nations and Inuit Home and Community Care • Child and Family Services – First Nations Child and Family Services • Recreation • Jordan's Principle • Baby-friendly Initiative • Building Healthy Communities • Transportation	• Family First • Canadian Diabetes Educator Certification / Diabetes Education Resources • Public Health • Mobile Clinic • Healthy Babies • Mental Health • Spiritual Care • Recreation Centres • Community health workers • COPD Inspire Program • Telecare

Moving from today to the future

The vision for the future is based on evidence, informed by PCTs' input, and aligns with jurisdictional practices

	Highlights of Current State	Highlights of Future State
Service Model – Highly Effective Teams	• Variable capacity within local communities with **high volumes of patients travelling to Winnipeg** to receive care • **Inequitable access to specialist care** despite high volumes of patients with morbidities who require access to multiple specialists • **Variable capacity and means within local communities for prevention**, early detection and early management of chronic diseases	• Broaden the **inter-professional supports and scope of practice for primary health physicians and primary health providers** to bring care closer to home • **Implement community-based case management and care coordination,** including for Indigenous communities • Develop **education and skill building tools for patients** and caregivers to promote self-management, including for diabetes • Strengthen relationship with primary prevention resources (e.g., Public health, community partners, exercise is medicine)

Service Standards and Pathways – Coordinated Delivery Systems	• **Variable standards and practice for primary health prevention, screening, and intervention** across the province
	• **Inconsistent care pathways** to support the flow of patients throughout the system
	  ◦ **Inconsistent methods of communication** between specialists and primary health physicians
	• **Variable coordination of care in the community**, including gaps in data sharing between ED and Primary Health providers
		• **Establish a data sharing platform** to facilitate sharing of patient information between care providers
		  ◦ **Improve patient access to their own health data**
		• **Increase usage of e-consults and telehealth/telehomecare** to create capacity province wide
		• **Implement standardized pathways for primary health**, and clearly define their role in early prevention, screening and intervention, particularly for obesity and diabetes prevention
		  ◦ **Standard referral and return of patients to primary health**, and ensure roles and responsibilities are clear
		  ◦ **Standard tools to support primary health** for prevention and screening
		• **Register all Manitobans with an enhanced My Health Team 2.0** to ensure every patient has access to an inter-professional health "hub" from their home community
		• Enhance **pain management services** through alternate modes of care delivery (i.e., virtual consults, and self-management)

Provincial view of the future vision

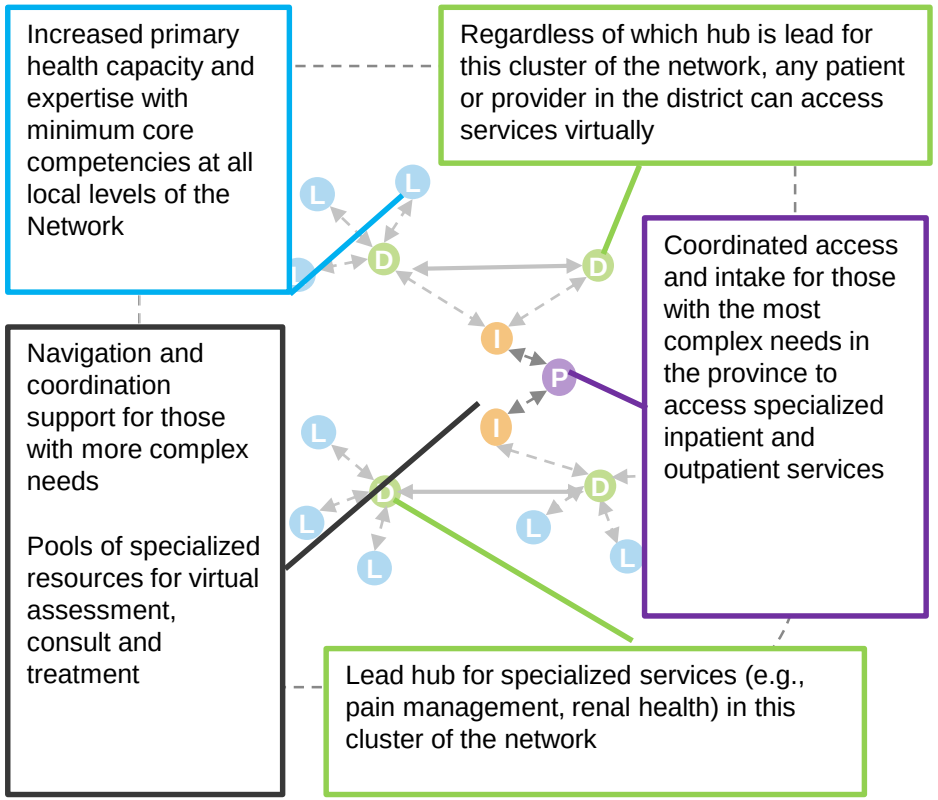
Future Vision: Manitoba will coordinate planning for service models, standards, pathway changes, and provider roles to

- Improve patient access to coordinated care pathways from primary health to specialists
- Build up capabilities for early identification, assessment, intervention, and patient self-management
- Address care for patients with specialized needs
- Enable professionals to practice to full scope of work

Key features of the future vision include, but are not limited to:

- Enhanced **delivery and coordination of care closer to home** as the foundation of the future model with enhanced **inter-professional teams**
  - Enhanced My Health Teams serve as a **"hub" for patients in their home community/region to enhance local access** on an ongoing basis for chronic needs (e.g., re-access with relapse, symptom management for flare-ups) and reduce need for travel to specialists (e.g., **Insulin Mentorship Program)**
  - **Extended reach of specialized capabilities** at all Network levels through **virtual, mobile,** and other remotely delivered models (e.g., Patient centred specialist medical homes; Manitoba Diabetes Integration Program mobile team outreach to First Nation populations)
- **Standardize and coordinate care** within and across all Network levels
  - Consistent use of **standardized care pathways** (i.e., COPD INSPIRED, Diabetes System of Care in WRHA, Renal nephrology pathway) in alignment with leading practices
- Develop, expand, harmonize **education and self-management tools/programs** to enable consistent patient engagement in their care management on an ongoing basis (e.g., teleCARE/teleSOINS diabetes clinics; arthritis education; Dial a Dietitian; Healthy Eating Toolkit, COPD Action Plans, Get Better Together)
- **Standardize access for the most complex needs** to specialized resources (e.g., provincial MS clinic; rheumatologist; endocrinologist) **Improve patient access** to their own health data

Illustrative example of network hubs working together



Provincial view of the future vision

Other key features of the future vision include, but are notlimited to:

Support enhancement of capabilities and optimize scope of practice and **bridge the gap between specialists and primary care providers**

- **Primary health and community health team capabilities** are enhanced and consistently **supported provincially** (e.g., Rapid Access to Consultative Expertise, shared care models, Extensions for Community Healthcare Outcomes (ECHO), Manitoba Patient Access Network, staffing guidelines for services)
- **Standardize prevention, screening, early intervention, and treatment** through the inter-professional team (e.g., primary health, psychologists, community, public health, educators,)
- **Increase outreach to Indigenous** and patient populations in rural/remote and Northern areas (e.g., Aboriginal Diabetes Initiative, First Nations and Inuit Home and Community Care, First Nations Child and Family Services, Nursing Stations)
- Increase **coordination between services to improve access to provincial and federal prevention and wellness programs** (e.g., Canada Prenatal Nutrition Program, Jordan's Principle, Families First Program, Healthy Baby Healthy Child, community health works, etc.)
- Create a foundation of work with primary care providers including access, **shared health records, hours of availability**

Service standards and provider roles | High Impact, Low Volume

Service standards and provider roles are outlined across the Network Model

	Service Standards	Provider Roles
Provincial Referral Hub	• **Provincial clinical governance** to provide standards and quality assurance for services including diagnostics • Provincial **specialized clinics** with a hybrid in-person / virtual delivery model (e.g., expand on MS clinic model for specific diseases such as rheumatoid arthritis, lupus, IBD, Tick-Bourne Disease)	• **Inter-professional teams with specialized expertise across sub-specialties** (i.e., endocrinologists, rheumatologists, gastroenterologists) will provide treatment for patients with **high complexity cases** • **Advisory role to generalists** at district and local hubs of the network (e.g., provide guidelines for symptoms and early diagnosis of disease;) using in-person or virtual methods • **Dedicated itinerant model** to support patients and providers at intermediate and district hubs of the network
Intermediate Referral Hub	• **Clinics for acute flare ups and specialized long-term disease management** (i.e., Chronic Pain Clinic)	• **Inter-professional teams with specialized expertise across sub-specialties** to coordinate care for patients of low to moderate acuity • Specialists will periodically **return to Provincial hub for training** to expand care for patients outside of Winnipeg • Indigenous Health Patient Services provide culturally appropriate services, resources and education for Indigenous patients and families within WRHA with linkages to their respective communities.
District Health Hub	• **Enhanced My Health Teams will serve as a "hub"** for patients in their home community/region to enhance local access on an ongoing basis for chronic needs and reduce need for travel to specialists • Coordination for patient to receive long-term disease management with providers at local hub to generate access closer to home	• **Generalists** (i.e., Allied health, pharmacists, psychologists etc.) to **provide tertiary prevention** to stabilize and minimize acute flares
Local	• Standard tool kit to support primary health providers in accessing appropriate **resources for patient self-care, warning signs and symptoms, and patient self-management of disease**	• **Standard screening and early intervention programs** through primary health providers • **Provide follow-up and long-term disease management** through inter-professional teams (e.g., pharmacists, nurse practitioners, physician assistants, psychologists, OT/PT etc.) • **Partner with community organizations to support prevention, wellness, and disease management** (i.e., Health eating programs, Dial a Dietitian, Recreation, Massage Therapy, smoking cessation etc.) • Enhanced use of IT self management

Service standards and provider roles | Prevention oriented, high volume

Service standards and provider roles are outlined across the Network Model

	Service Standards	Provider Roles
Provincial Referral Hub	• **Standard discharge and transfer to community** including screening for re-admissions • **Virtual methods will be standardized** various applications including: a single source of patient information (i.e., EMR), communication tools (i.e., telehealth), education tools, eConsult, and technology for home monitoring that will be used at all hubs of the network • Delivery of **tertiary and end-stage care** (e.g., kidney transplant)	• **Inter-professional teams with specialized expertise across sub-specialties** (i.e. endocrinologists, rheumatologists, podiatrists, respirologists) will collaborate to develop & manage treatment plans for patients with **high complexity/ cases** • **Provincial resource team to provide virtual consults** to providers across the province
Intermediate Referral Hub		• **Inter-professional teams with specialized expertise across sub-specialties** to coordinate care for patients of low to moderate acuity/ comorbidities • **Mobile teams and clinics travel** to district and local hubs of the network to **provide care for specialized populations** (i.e., First Nations Manitoba Diabetes Integration Program, resource team to support home dialysis or hemodialysis at federal health stations

Service standards and provider roles | Prevention oriented, high volume

Service standards and provider roles are outlined across the Network Model

	Service Standards	Provider Roles

District Health Hub	• **Enhanced My Health Teams will serve as a "hub"** for patients in their home community/region to enhance local access on an ongoing basis for chronic needs and reduce need for travel to specialists
	  • Coordinate and provide care through various primary health providers using **defined pathways and transition points between providers for short-term and long-term disease management** (e.g., allied health, primary health physicians, psychologists, etc.)
	  • **Coordinate access and inform patients** and patient care providers on federal and provincial community programs
	• **Consistent access to specialty clinics and programs** (Insulin Mentorship Program, Community-based dialysis clinics, support groups, Cardiac Rehab- Home-Based program) to keep patients closer to home
		• **Generalists** (i.e., Allied health, pharmacists, psychologists, etc.) to **provide tertiary prevention** to stabilize and minimize acute flares

Local	• Standard tool kit to educate and support primary health providers in accessing **appropriate resources for patient self-care, warning signs and symptoms, and patient self-management of disease** (e.g., Diabetes Canada web site, Diabetes Compendium) • Provincial expansion of INSPIRED Program for COPD patients to **improve self-management and reduce reliance on hospital care** • Provincial expansion of Rapid Access to Consultative Expertise phone lines and eConsult to **build primary care capacity in the community**	• **Partner with community organizations and complimentary services** to support prevention and wellness (i.e., Canada Prenatal Nutrition Program, National Native Alcohol and Drug Abuse Program, First Nations and Inuit Home and Community Care, Mental Health and Addictions, Recreation, Manitoba Fitness Council)

Service standards and provider roles | Multiple Chronic Disease

Service standards and provider roles are outlined across the Network Model

	Service Standards	Provider Roles
Provincial Referral Hub	• **Standard discharge and transfer to community** including screening for re-admissions (COPD Risk for Readmission tool) • **Virtual methods will be standardized** various applications including: a single source of patient information (i.e., EMR), communication tools (i.e., telehealth), education tools, eConsult, and technology for home monitoring that will be used at all hubs of the network (telehomecare)	• **Inter-professional teams with specialized expertise across sub-specialties** to assess and **treat high complexity cases** (i.e., gastroenterologist, neurologist, rheumatologist) • **Provincial resource team to support providers** across the province and consult on cases throughout the hubs as needed (i.e., Project ECHO) • **Coordinate with district and local hubs** through My Health Teams
Inter-mediate Referral Hub		• **Inter-professional teams of general internists** to assess and care for patients of **low to moderate acuity** • **Provide tertiary prevention and patient management of disease** and minimize acute flares

District Health Hub	• **Enhanced My Health Teams will serve as a "hub"** for patients in their home community/region to enhance local access on an ongoing basis for chronic needs and reduce need for travel to specialists
	  • **Coordinate follow-up and long-term disease management with inter-professional teams** (e.g., internists, allied health, primary care physicians, psychologists, telecare, etc.)
	  • **Coordinate efficient follow-up process post-discharge** from acute care to reduce readmissions (i.e., automatic 7-day follow-up)
	• **Consistent access to specialty clinics and programs** (e.g., Chronic Pain Clinic, pulmonary and cardiac rehab programs, Get Better Together support group model) to keep patients closer to home
		• **Generalists** (i.e., Allied health, pharmacists, psychologists , etc.) to **provide tertiary prevention** to stabilize and minimize acute flares
		• Work with Social Services to support patient and caregivers

Local	• Provincial expansion of Rapid Access to Consultative Expertise phone lines to **build primary care capacity in the community and provide quick access to specialist support** • Standard tool kit to support primary health providers in accessing appropriate **resources for patient self-care, warning signs and symptoms, and patient self-management of disease** (e.g., COPD and CHF Action Plans)	• **Primary care homes with inter-professional primary health team**s supporting physicians (i.e., Nurse practitioner, allied health, social work, spiritual care, Indigenous Health Patient Services) • **Partner with community organizations to support prevention and wellness** (e.g., Canadian Obesity Network, Commit to Quit Smoking Cessation, Living Well with Pain, Support Services for Seniors, Seniors without Walls etc.)

Opportunities for innovative service delivery

Innovative service delivery and improved access to care can be achieved through digital technology, including associated information and technology requirements, as well as integrated support services including diagnostics, laboratory, patient transport, Emergency Services, infrastructure and equipment. The table below highlights key elements for the Chronic and Complex Medicine PCT as they are unique to those outlines in the Provincial chapter. Further, Key Performance Indicators have been outlined to assess the implementation of this model.

Digital Health	• Enhanced My Health Teams will require a platform for virtual documentation • Video-conferencing hubs that reduce travel for patients in northern and remote communities and support health care providers using Project ECHO • Patient and caregiver monitoring (e.g., self-management apps, smart watches tracked by care providers)
Diagnostic Services	• Build up capacity to utilize point-of-care testing in local hubs to enhance patients' self-management of chronic disease (i.e., diabetes, congestive heart failure, and anticoagulation) through monitoring and analyzing medication outcomes
EMS/Patient Transport	• *There are no major EMS/Patient Transport considerations that are unique to this PCT*
Infrastructure and Equipment	• Funding from health authority to support development of specialist clinics (e.g., MS clinics, IBD clinics) • Equipment for Home-based treatment (e.g., Home dialysis)
Prevention	• Expanded community capacity to manage population effectively (e.g., COPD system of care, spirometry testing; patient registries)

Key Performance Indicators

1. Reduced number of unnecessary transfers to Winnipeg and improve access to specialist consults through expanded use of alternate modes of care delivery (i.e., virtual, itinerant care models)
2. Increased number of Manitobans registered with an enhanced My Health Team to ensure every patient has access to an inter-professional health "hub" from their home community
3. Increase number of patients with diabetes who are able to self-manage care through education and skill building tools to reduce reliability on health providers
4. Improved access and coordination of care through increased number of inter-professional care team models

Appendix – Future Provincial Clinical Services Pathway – Diabetes