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Manitoba's Clinical & Preventive Services Plan

Investing in Better Care, Closer to Home

PRIMARY HEALTH AND COMMUNITY SERVICES 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

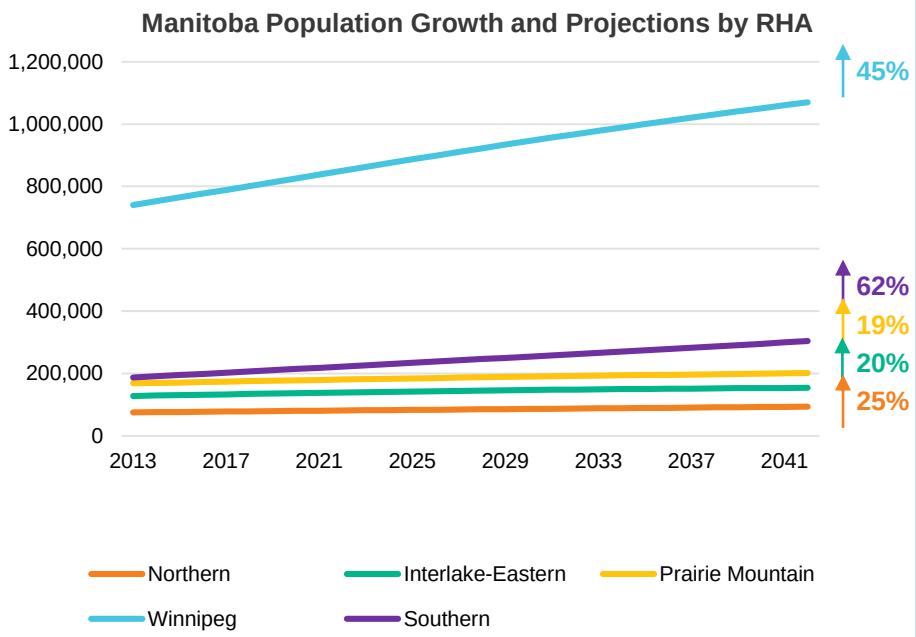
The **largest growth** is projected to occur with the **80+ and 60-70 year old cohorts** however Manitoba remains the only province where youth under 15 exceed the older population

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

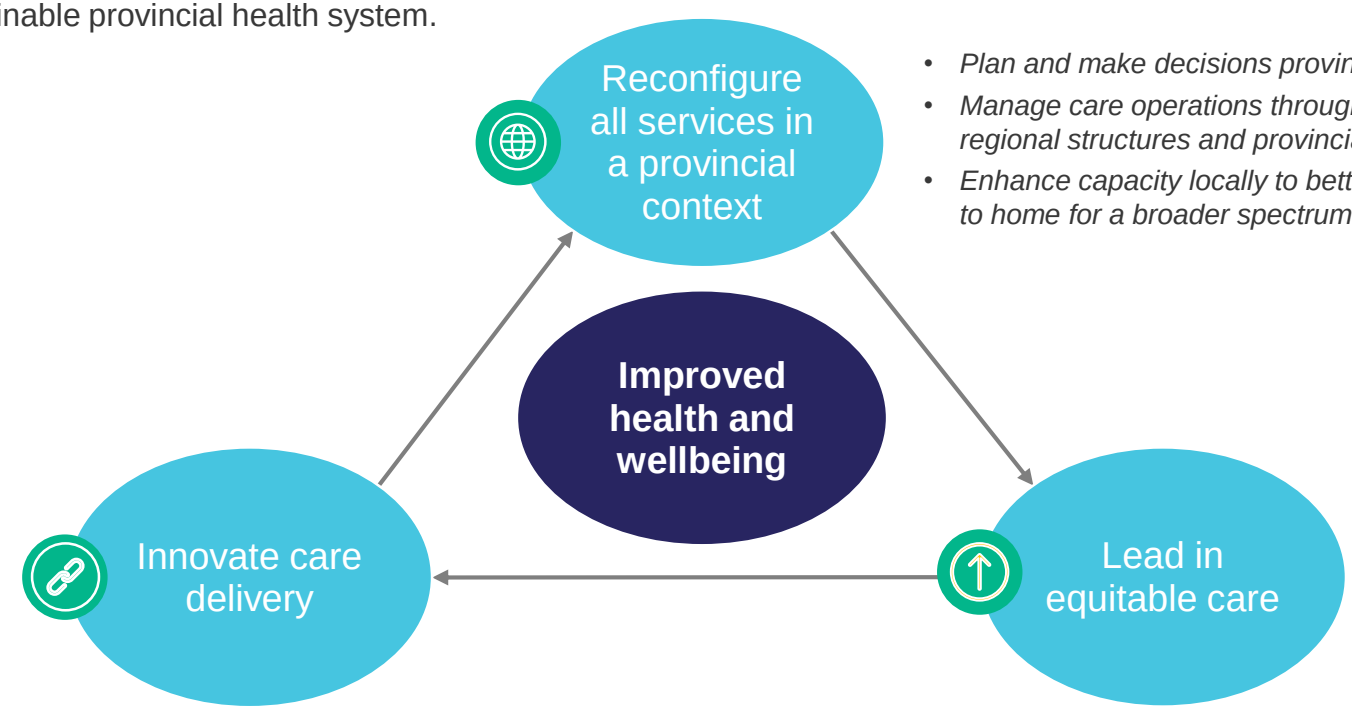
2x More paramedics per 100,000 residents than the Canadian average and more female paramedics (national average: 32%)

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

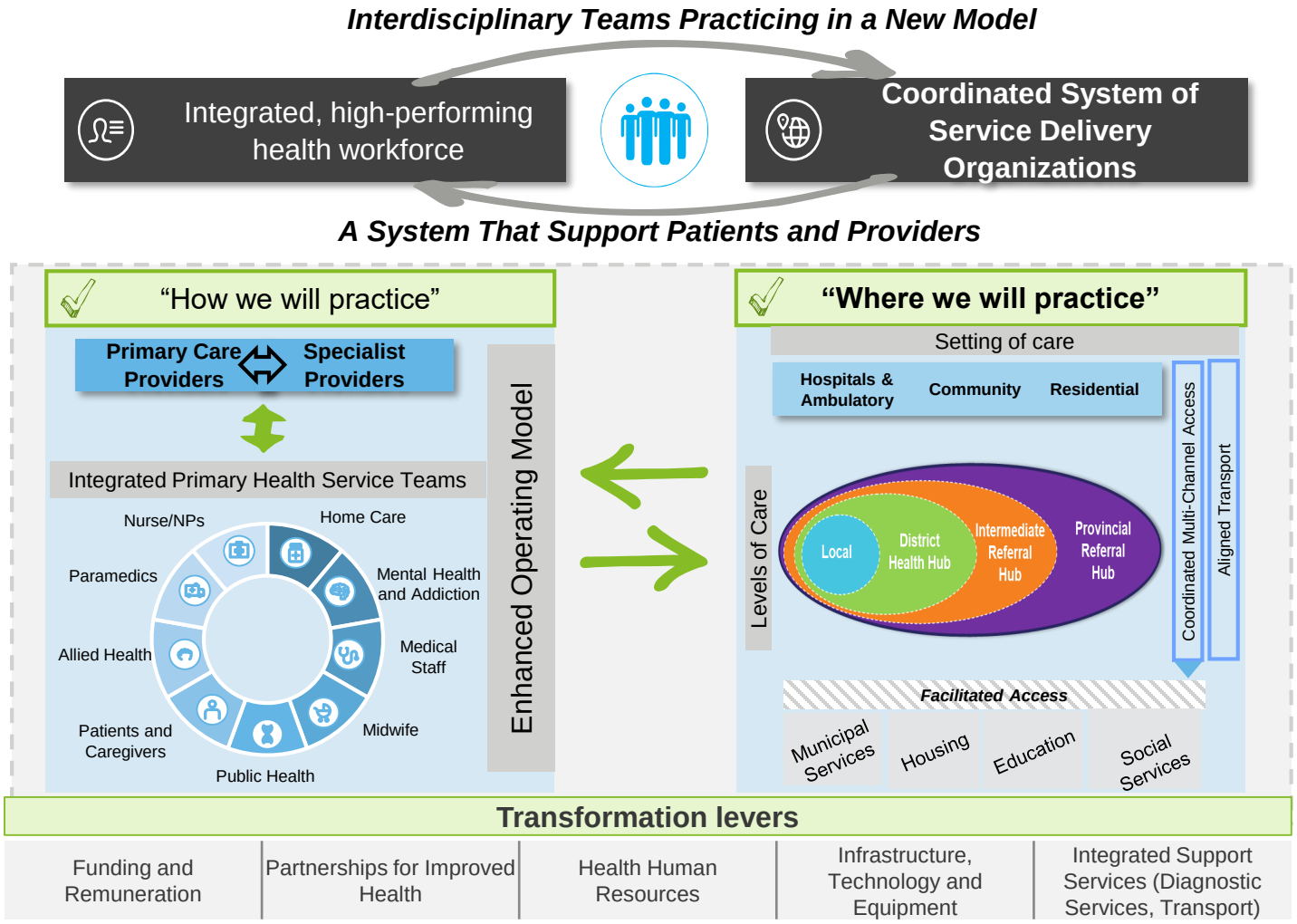
… virtual tools to bring care closer to home

… 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

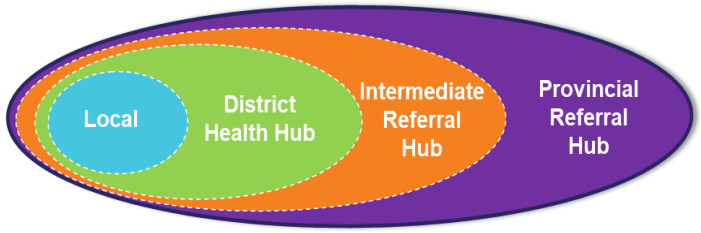
An integrated network for accessing and delivering services is core to the new provincial model



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**.

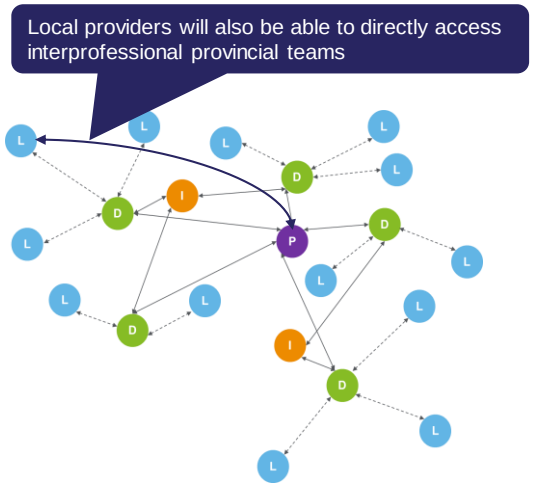


L **Local Area Hub**
Integrated network for prevention and screening, transitional care, community based support and rehab, and primary and community care

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

Primary Health and Community Services

Current state and case for change

While multiple initiatives are underway, key risks identified in Manitoban's health status suggest a need for continued enhancement of integrated approaches to healthy living, prevention, and Primary Health and Community Services

Multiple initiatives are underway to enable care integration throughout the province

- **Primary Health initiatives**
  - New models of primary care are currently being implemented including MyHealth Teams and Home Clinics, as models to foster care continuity and integration particularly as it relates to mental health, rehabilitation, home care, public health, long term care/healthy aging and chronic disease prevention and management
  - A five-year Primary Care Strategy has been initiated with the goal of increasing access, continuity and comprehensiveness of Primary Care in Manitoba. The strategy supports a shift away from siloed care towards interprofessional care with a long-term view of health
- **Community Service initiatives**
  - Multiple initiatives are underway, including: Manitoba Homecare Hub to support planning and communications; The Self and Family Managed Care (SFMC) program; Priority Home strategies, delegation from Nurses to Home Care Attendants (HCAs)

Key medical and social risk factors for poor health signal a need for shifts in preventative and population health

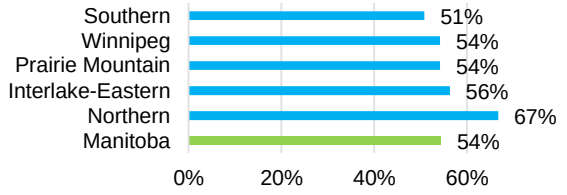
- **Health risk factors**
  - In FY15/16, over half of Manitobans aged 40+ had one or more chronic conditions, of which about 20% had 3+ conditions
  - Manitoba's diabetes prevalence is above the Canadian rate of 7%. Prevalence of diabetes in NRHA is 2x the provincial rate
- **Medical complexity:**
  - ~5% of the population was dispensed 10+ prescription drugs within a one-year period
  - Winnipeg has higher rates of medically complex individuals based on mental health concerns than other parts of the province
  - 68% of home care clients have acute or chronic pain (based on data available in WRHA)
- **Social complexity:**
  - Approximately 13% of Manitobans have three or more social complexities. Poverty is a key contributor to social complexity: over half of socially complex Manitobans live in the poorest areas.
  - Income: Research has shown that the lowest income Manitobans are 1.9x (rural) to 2.9x (urban) more likely to die prematurely than highest income Manitobans. This is important as more than 1/5 Manitobans lived below national low income cut-offs in 2016.

Highlights of health behaviours by RHA

Highlights of health status	MB	NRHA	IERHA	PMHA	WRHA	SH-SS
Has Activity Limitations	35%	35%	36%	34%	36%	35%
Binge Drinking	46%	**59%**	49%	47%	48%	**39%**
High General Mental Health (SF-36)	40%	44%	39%	43%	38%	41%
Current Smoker	20%	**33%**	23%	20%	19%	19%
% Overweight or Obese	56%	**65%**	**62%**	59%	54%	59%

For Health Status Statistics only: Rates circled in yellow indicate an area's rate was statistically different from the Manitoba average

Chronic Disease Prevalence, 2012, ages 40+



Source: MHSAL – Discharge Abstract Database and Manitoba Community Health Assessment Network (2017) *Primary Health Care and Community Services;* Wait Times Reduction Task Force (WTRTF): Final Report (2017); WRHA (2017) *Clients in the WRHA Home Care Program*. Note: Data was specific from this report and comparable data for other regions were not identified at the time of this analysis; Statistics Canada Community Health Survey, Manitoba Community Health Assessment Network (2017), Emergency, Critical Care & Acute Medicine; Statistics Canada, Annual Estimates, Canadian Community Health Survey. URL: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009607; CHAN, 2018

Current state and case for change

Data trends suggest opportunities for Primary Health Services to support avoidance of unnecessary hospital-based care

Health utilization patterns suggest an opportunity for primary health and community services to enable care closer to home and prevention of avoidable care	**Reducing avoidable health utilization**
	• ~49-59% of ED patients presented with low acuity needs (CTAS level 4-5) which might have been addressed through enhanced access to regular primary health services or urgent care
	• ~20% of Manitobans with a primary care provider are high users of health services, a medically complex patient, and/or a socially complex patient
	  • Top 5% of "heavy users" accounted for 45% of all hospital days in the province and 90% of all ALC days
	  • Having a mental health disorder was a significant factor for heavy use
	Mitigating risks through prevention
	• 41% of home care clients are at risk for falls (based on data available in WRHA)
	• Reported increase in complexity and acuity of care needs (e.g., mental health, dementia care)
	Addressing challenges in continuity of care
	• Providers and patients report long wait times to access basic specialist consults to support consultations. Limitations in processes, pathways, and technology impact the ability for primary care providers to connect with specialists in a timely manner

Challenges with the supply and demand of primary health providers - particularly in Northern/remote regions, after hours, and on weekends.	• **Linkages with primary health teams:** Almost one in three community-dwelling Manitobans do not see a primary care provider regularly. Of those who see a primary care provider regularly, approximately 40% travel outside their MyHTs for care, emphasizing the importance of local responsiveness to meet the needs of rural and remote/Northern communities • **Hot spots:** Communities in rural and northern areas persistently unable to sustain adequate access to regular primary health services ("hot spots") from 2016-2018, driven by increases in Northern and Southern populations, often due to recruiting and/or to retaining Physicians and/or Nurse Practitioners (NPs) • **Linkage with federal supports for Indigenous populations:** The Manitoba Wait Times Report noted inconsistent and unreliable care available at both federal and provincial nursing stations. Unfortunately, for these patients, the only other option for primary care may be attending the ED when they occasionally have the opportunity to travel to a community with a health care facility. • **ED and primary care in rural areas:** Many ED sites are run by a local family physician responsible for covering the ED, inpatient ward, dialysis unit, cancer care and adjacent PCH, all while retaining primary care practices, often in the hospital (Wait Times, 2017). When the same physicians are responsible for both community primary care and the ED, primary care services are often displaced to provide urgent care in the ED – clinic appointments are cancelled or run late. • **Availability:** Variable number of clinics offer early morning, evening, and weekend appointments. Inconsistencies in types of services available in primary health teams and variable use of advanced access principles • **Limited options:** for prevention, self management, self referral, access to information/education, awareness

Source: Wait Times Reduction Task Force Final Report, 2017; Primary Care Capacity Planning Provincial Roll-up Report, Primary Health Care Branch, MHSAL (2018); Future of Home Care Services in Manitoba Report, Dec 2016, WRHA (2017)

Current state and case for change

Data trends suggest an opportunity to enhance the capacity and capabilities in Community Services, including Personal Care Homes, to provide restorative, supportive and rehabilitative care closer to home

Inconsistent accessibility to home care services and access to community-based rehabilitative and restorative care

- **Consultative approach to care:** RHA consultations have identified an inability to provide these services consistently across the region, noting financial and personnel resources as constraints and need for greater standards. Limited health human and financial resources, challenging needs, and increased need to support hospital discharges are noted to have contributed towards a "health/medical model" in home care.
- **Implications for patient flow:** 24% of ALC patients were waiting in acute care for home care, primarily older adults in poor health and living in lower income areas. In WRHA, over 2,200 days in rehab were spent waiting for home care and PCH services
- **Access to rehabilitation:** A recent scan of rehabilitation services identified consistent challenges across RHAs as it relates to demand exceeding capacity, underutilized scope of practice, imbalance of needs and staff training, underutilization of virtual models, and variability of provider roles and services in home care and in PCHs

PCH wait times, delays to access home care services, or appropriate supports in the community contribute to increased ALC days in acute care

- **Appropriateness for PCH:** 33% of newly admitted WRHA PCH residents were assessed as having potential to be supported through non PCH settings. Manitoba rated the highest across jurisdictions reviewed in this report. 10% of newly admitted PCH residents were assessed as clinically similar to supportive housing tenants based on a recent review
- **Wait times:** 49% of ALC patients were waiting for placement in PCH – they represented 86% of ALC days. In WRHA, 15% of clients spent an average of 20 days waiting for placement into PCH
    - Priority Home Transitional Home Care Service has demonstrated prevention or delay in PCH placement by promoting home as the primary discharge destination and providing up to 90 days of short term, intensive and restorative services
- **Capabilities:** While supportive housing, independent older adults' housing, and PCHs are all housing options for older Manitobans, there is an expected need to broaden the capabilities of these settings to support increasingly complex populations (e.g., dementia, behavioural challenges).

Long Term Care Wait List Volumes, FY17/18

RHA	Total Eligible Persons Paneled for Placement			Cumulative Total Number of Persons on Wait list ending March 31st		
	PCH	CC	SH	PCH	CC	SH
IERHA	394	24	47	154	14	69
NRHA	94	20	6	45	26	2
PMH	717	1	12	214	8	1
SHSS	376	0	75	302	0	41
WRHA	1334	60	336	136	14	95
Total	**2915**	**105**	**476**	**851**	**62**	**208**

Source: Manitoba Health Policy Centre. Who is in our hospitals and why? September 2013; Clients in the WRHA Home Care Program, Rehabilitation Services in Manitoba, Environmental Scan of Current Knowledge and Models of Care, 2017.

Moving from today to the future

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

	Highlights of Current State	Highlight of Future State
Service Model - Highly Effective Teams	• **Long wait times** to access specialists • **Long wait times** for home care and PCH services • **Variability** of primary health team capabilities • **Variability** in integrating the full scope of the interprofessional team into primary health • **Recruitment and retention** challenges	• Standard processes for and consistently available **provincial pool of coordinated expertise** (e.g., tech enabled consultation) in priority areas of need, including: geriatricians for complex older adults, NP/APN/Paramedic to carry out integrated care plan to enable chronic patients to manage home, mental health workers and coaches, midwives to support birth closer to home • Address high users and complex user needs and free capacity of Primary Health Physicians through greater reliance on **allied health** (e.g., addressing cardiovascular/ musculoskeletal concerns, diabetes and chronic conditions) and **nursing practitioners** (e.g., prescribing capabilities) • Focus Primary Care Physicians' capabilities in addressing medical management of older adults, mental health and addictions, maternal/child needs, more complex chronic diseases • Develop standardized patient pathways to support a more seamless care journey; implement patient navigators when the patient pathway requires it (for more complex or rare conditions) • All teams supported through provincial virtual consultation resources (e.g., telehealth, e-consult, RACE)

Service Standards and Pathways - Coordinated Delivery Systems	• **Persistent hot spots** for primary health access and limitations in nursing station services
	• Challenges with **after hours** support options beyond the ED
	• PCHs see **lower acuity patients** who could be managed in alternate settings of care (e.g., supportive housing, enhanced home care)
	• **Variability** in community-based access to restorative, rehabilitative, or supportive care due to lack of accessibility to allied health resources, resulting in focus on consultative, medical focus
		• **Enhanced capabilities** of Primary Health Services at the District and Intermediate levels of care to free up specialists and hospital-based services, while providing rapid access for local levels closer to home and consistent linkage with nursing stations
		• **Greater consistency** in the "basket" of Primary Health services and capabilities within each level of care to support equity of access
		• **Consistently integrated** virtual enabled models of care to support consultation, assessment, and care delivery for Primary Health and Community Services including:
		  ◦ Virtual home monitoring and support for self management for Primary Health Services
		  ◦ Virtual delegated care or other forms of virtual models for restorative, supportive, and rehabilitative Home Care (e.g., Palliative Care, Complex Paediatrics, targeted areas of restorative and rehabilitative care)

Provincial view of the future vision

Future Vision: Enhanced provider capacity and capability for prevention and to identify risks earlier, shift care from hospital to community settings, and provide care as close to home as possible, particularly for priority needs

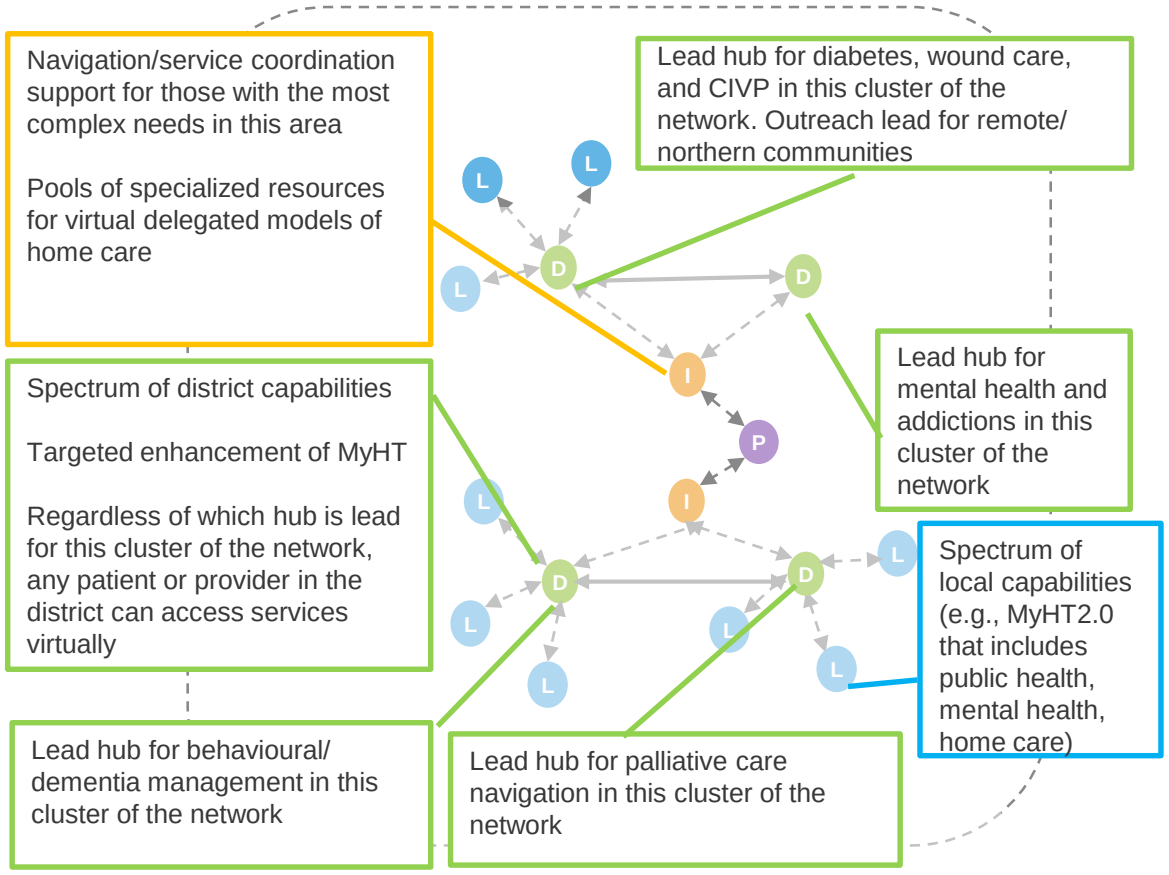
Coordinated planning of service models, standards, pathway changes, and provider roles will:

1) Create consistent capabilities to manage priority areas (older adults, mental health, chronic disease, social/medical complexity)
2) Streamline and standardize care that results in enhanced quality outcomes
3) Reduce avoidable ED and hospitalization
4) Support earlier discharge from acute care

Proposed changes:

- **Service standards** – Advance the consistency and clinical capabilities at intermediate levels of care
- **Service model + Provider roles – Access to primary health** – Increase the consistency and clinical capabilities at local and district levels of care – starting with hot spots
- **Service model + pathways – Virtual access** – Integrate virtual access within and across network hubs, including specialist care and outreach to rural, remote/Northern communities (e.g., Indigenous/ Francophone communities)
- **Provider roles + pathways – PCH** – Standardized pathways to PCH placement and enhanced options in the community

Illustrative example of network hubs working together



Service standards and provider roles

	Service standards	Provider roles
	There are no provincial referral hub related services anticipated for Primary Health and Community Services	
Intermediate Referral Hub	• Improve coordinated and virtual approaches for timely access to moderate acuity and/or highly specialized Primary Health and Community Services capabilities and resources • Expected to support avoidance of ED visits/hospitalization and reduce ALOS/ALC by supporting transitions back to the community with more complex needs	• **Primary Health Services**: Navigation support for patients identified as having the most complex needs; advanced nursing skillsets (e.g., complex wounds), coordination with paramedics • **Community Services**: Coordination of specialized or limited number of resources to manage delegation of virtual care models (e.g., Palliative Care Nursing, OT, PT, SLP, pediatric dentistry) • **PCH:** PCH with dementia/behavioural support units. Alternate living for younger adults with cognitive/behavioural impairments (e.g., ABI)
District Health Hub	Deliver a spectrum of district capabilities which may include: • Community based specialty services (e.g., community cancer care, palliative care team, transitional care, and screening for specialty needs) • Expanded capabilities of targeted My Health Teams to provide a minimum "basket" of services in each district with opportunities to share resources Expected to support avoidance of ED visits/hospitalization and reduce ALOS/ALC by supporting earlier discharge home and management of more complex needs	• **Primary Health Services**: Enhanced capabilities to address priority areas, reducing risk for ED/hospitalization, and promoting care at home – e.g., ◦ General rehabilitation ◦ Advanced nursing/wound care ◦ Basic geriatric/dementia care ◦ Basic mental health and addictions care ◦ Falls prevention ◦ Chronic pain ◦ Diabetes, foot care, education ◦ Social work/social services ◦ Public health ◦ Pharmacy ◦ Midwifery ◦ Pediatric dental surgery • **Community Services:** Enhanced to manage more complex needs for earlier discharge home with virtual support to local home care teams (e.g., stroke, basic MSK) • **PCH:** Develop additional supportive housing options to reduce wait time for PCH
Local	Multiple modes of access for patients to access regular care (e.g., in-person, virtual, satellite clinics, itinerant care) to extend and support equitable access to local hubs (e.g., MyHTs) across the province Deliver a spectrum of local capabilities which are responsive to local population needs and meet minimum service standards–e.g.,: • 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 • Local primary care providers (e.g., GP, NP) as 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 • Support for early risk identification, avoidance of ED visits/ hospitalization, prevention of deterioration	• **Integration** with existing My Health Teams, Home Clinics, Home Care, and other Primary Health and Community Services within a network to support regular access to a community team that offers basic medical and prevention services in all localities delivered in collaboration with an interprofessional team. • **Linkage** with other health providers (e.g., public health, dentists/oral health promotion) and **outreach** to rural/remote/Northern regions with limited access to care, including nursing stations, to coordinate and enhance community based care, screening/prevention, chronic disease management, population health, and aging in place • **Primary Health**: Enhanced capability and capacity of physicians, nurses, public health, other local primary health providers to manage shifts towards increased local services in mental health and addictions, aging in place, support for the frail elderly, basic maternal and child health, chronic disease management, rehabilitation and restorative care • **Community Services**: Local coordination of home care services with restorative, rehabilitative, supportive focus beyond medical/consultative using virtual or in person models using standardized models. • **PCH**: Basic personal care homes to continue to supporting patients who can no longer manage at home

Evolving My Health Teams

My Health Teams are envisioned as a collaborative model to enable access to a community-based team of health providers closer to home

The My Health Team (MyHT) model is a Manitoba-specific model intended to bring multiple providers together to provide care closer to home. The strength of the MyHT is to be responsive to local needs and address population differences. MyHTs operate in both in-person and online modes of delivery across clinics and communities.

The MyHT model has been successful in enrolling 24% of insured residents to clinics that are part of MyHTs and attaching over 24,000 patients, exceeding initial goals. 13 MyHTs were in place or planned across Manitoba by 2018 with consistent service standards but can vary broadly in their location and make-up of providers and clinical capabilities accessible, as outlined in the table below, with an increasing focus on building clinical competencies through a range of inter-professionals.

Overview of current MyHTs (current as of November 2018)

RHA	MyHT	Clinics	Related Community Organizations	Services Offered
Prairie Mountain Health	Brandon Area	• Western Medical Clinic - FFS • 7th Street Access Centre • Meredith Clinic - FFS	• Western Manitoba Cancer Centre	• Cancer Shared Follow up Care • Mental Health • Chronic Disease Management • Complex Patient Support • Complex Needs Medication Management
	Swan Valley Area	• Swan Valley Primary Care Centre	• Sapotaweyak Cree Nation	• Complex Needs Support for Medications • Outreach to Vulnerable Populations • Mental Health Support • Chronic Disease Support
Interlake Eastern Regional Health Authority	Selkirk South	• Selkirk Medical Associates - FFS • Selkirk Quick Care Clinic	• Addictions Foundation of Manitoba • Canadian Mental Health Association	• Currently in planning
	Lake Manitoba East	• Ashern Health Centre FFS • Pinaymootang Health Centre FFS • Lake Manitoba Health Centre • Little Sask. Health Centre • Eriksdale Health Centre • Lundar Health Centre • St. Laurent Community Health Centre • Woodlands Community Health Centre • Mobile Clinic • Percy E. Moore Clinic (Ongomiizwin Health Services, UofM)	• Little Sask FN Health Centre • Lake Manitoba FN • Pinaymootang FN • OHS	• Currently in planning

Source: Chateau, D., Katz, A., Metge, C., Taylor, C., McDougall, C., & McCulloch, S. (2017). Describing Patient Populations for the My Health Team Initiative. Manitoba Centre for Health Policy, Winnipeg, MB; Community Health Assessment Network for Wave One Launch. (2018). Primary Health & Community Services Provincial Clinical Team. Manitoba. Shared Heath, 2019

Evolving My Health Teams (cont.)

Overview of current MyHTs (current as of November 2018)

RHA	MyHT	Clinics	Related Community Organizations	Services Offered
Winnipeg Regional Health Authority	River Heights/Fort Garry	• Elemental Medical - FFS • Corydon Medical - FFS • Riverwood - FFS • Bison Medical (Bison) - FFS • Access Fort Garry/Corydon PC • Corydon Village Medical – FFS • Tuxedo Medical Centre – FFS • Sheldon Permack Med Corp – FFS • Bison Medical (Pembina) – FFS • Prairie Trails at Taylor - FFS	• n/a	• Chronic Disease Management • Clinical Pharmacy • Occupational Therapy • Tobacco Cessation • Social Work
	St. James/ Assiniboine South	• Assiniboine Medical Clinic - FFS • Westwood Clinic - FFS • Access Winnipeg West • Crestview Clinic- FFS • River West Medical Centre - FFS	• n/a	• Chronic Disease Management • Clinical Pharmacy • Occupational Therapy • Social Work
	Seven Oaks/Inkster	• Prairie Trails at the Oaks - FFS • Leila Medical Clinic - FFS • Kildonan Medical Clinic - FFS • Dr. Rakesh Gera - FFS • Access Nor-West (Nor-West Community Co-Op & Bluebird CHA) • LifeSmart Medical Clinic – FFS	• n/a	• Chronic Disease Management • Clinical Pharmacy • Occupational Therapy • Physical Therapy
	St. Boniface/ St. Vital	• Centre de Sante Saint-Boniface (Access St. Boniface) • Laxmi Medical - FFS • St Boniface Clinic - FFS • Family Medical Centre • Health Plus Medical Centre -FFS • Seine River Medical Clinic - FFS • Family Matters – FFS • River Park Medical - FFS	• n/a	• Chronic Disease Management • Pharmacological Management • Occupational Therapy

Source: Shared Health, 2019

Evolving My Health Teams (cont.)

Overview of current MyHTs (current as of November 2018)

RHA	MyHT	Clinics	Community Orgs	Services
Winnipeg Regional Health Authority	Downtown/ Point Douglas	• Eaton Place – FFS • Dr. Peter Kuegle Med Centre - FFS • Aikins Street Com Health Centre • Access Downtown • Mount Carmel Clinic • Hope Centre Health Care • Aboriginal Hlth and Wellness Centre • Klinic Community Health • Northern Connections Med Centre • McGregor Medical FFS • Nine Circles Community Hlth Centre • BridgeCare Clinic	• n/a	• Chronic Disease Management • Social Work
	River East/ Transcona	• Concordia Health Associates - FFS • Prana - FFS • Pritchard Farms – FFS • Primacy Regent Med Clinic – FFS • Gateway Primacy Med Clinic – FFS • Access River East • Access Transcona	• n/a	• Chronic Disease Management • Co-occurring Disorders Mental Health • Social Work
Southern Regional Health Authority	Morden/ Winkler Area	• Agassiz Medical Centre - FFF • CW Wiebe Medical Centre - FFF	• South Central Immigration Services	• Chronic Disease Management • Mental Health • Social Work
	Portage/Gladstone Area	• Portage Clinic - FFF • Gladstone Clinic (Seven Regions Health Centre)	• Long Plain Health Centre	• Chronic Disease • Mental Health • Prenatal • Pharmacy
	Francophone	• Centre Medical Seine - FFF • Centre de bien-être St. Claude & Haywood Wellness Centre • Clinique Notre-Dame Clinic	• Sante en français	• Social Work for complex psycho-social population • Community Health
	Steinbach Area	• Steinbach Family Med Centre - FFF	• n/a	• Mental Health • Chronic Disease Management • Pharmacy
Northern Regional Health Authority	NA			

Source: Shared Health, 2019

Evolving My Health Teams (cont.)

The future model will build on the successes of the MyHT model and enhance its spread and consistency through "My Health Team 2.0" as Integrated Local Community Health Hubs

My Health Team 2.0 will provide enhanced access to a more consistent range of clinical capabilities as a type of local hub in Manitoba's network model. My Health Team 2.0 is critical to supporting planned shifts in the future health system closer to home, via both in-person and virtual means. The vision for MyHT 2.0 retains the original intent and philosophy of team-based care and local responsiveness. In addition, MyHT 2.0 is expected to:

- Work in population focused approach to deliver care in collaboration with an interprofessional team, including home care, public health and other outreach services, virtually or in-person
- Foster greater collaboration with non-health funded or Indigenous communities
- Provide a broader and more consistent basic level of interprofessional care, including, for example: nursing, allied health, public health, mental health and addiction professionals, community paramedicine and pharmacists.
- Develop stronger alliances and collaboration with public health, midwifery, Indigenous communities and nursing stations, non-health funded community resources
- Deliver a broader range of clinical capabilities to support care closer to home, including care delivered through a range of in-person and virtually based providers addressing community-based:
  - Mental Health and Addictions
  - Rehabilitation and restorative care
  - Prevention and health promotion
  - Chronic disease management
  - Healthy aging in place through primary prevention, including support for the frail elderly living in the community (including PCH)
  - Basic maternal child health and outreach (pre-natal, birthing, post-natal, immunizations)
- Embed digital models of care to allow for increased reach both across different hubs, MyHTs and into more rural and remote/Northern communities
- Proactive outreach to Indigenous communities
- Local quality improvement across public and private practices with measurement of change and defined ownership around data and measurement

Considerations for success

There are multiple elements of a MyHT2.0 that are anticipated to be important for success in the future model, including, for example:

- **Multiple modes of access** (e.g., in-person, virtual, satellite clinics, itinerant care) to extend and support equitable access to MyHTs across the province
- **A "No wrong door" philosophy** – There is recognition that while multiple modes of access will be available to support access to care, each mode of access should support navigation and redirection if required to support
- **Capability and capacity building** – The nature of shifts in MyHT2.0 requires capability and capacity enhancements to leverage and where appropriate re-invest available resources in an integrated, coordinated manner to enable skill-development and enhanced connection
- **Recognition of local nuances to support continued engagement** – While there is identified need for greater provincial planning tables and governance in the CPSP, there is also recognition that there will always need to be engagement at local levels, particularly around MyHT 2.0 planning, governance, and remuneration considerations.

Through an enhanced set of capabilities, MyHT 2.0 is expected to play a key role in promotion of early prevention and mitigation of health needs (e.g., avoid unnecessary visits/admissions for older adults) and delivery of lower to moderate acuity/complexity care closer to home.

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 Primary Health and Community Services PCT as they are unique to this Provincial chapter. Further, Key Performance Indicators have been outlined to assess the implementation of this model

Digital Health	• Access to telehealth and virtual care consults, assessments, treatments, and remote monitoring will be used to provide streamlined linkages between primary health teams, allied health, and specialists, reduce unnecessary travel, and promote appropriate, earlier discharge home • Centralized referral and intake supports for navigation to streamline access to specialized services
Diagnostic Services	• Point of care testing to enhance local capabilities. Standardization and streamlining of basic diagnostic testing capabilities that would be available at local, district, and intermediate levels, with consideration for key metrics and quality standards (e.g., efficiency, turnaround times)
EMS/Patient Transport	• Linkages with paramedics to support community based care, outreach, and enhanced services particularly in rural and remote communities
Infrastructure and Equipment	• Consideration for use of shared spaces, particularly as health provider roles gradually shift to align with population needs
Prevention	• Linkages with municipal and social services partners and public health providers to support consistent prevention and self-management particularly in key areas of diabetes and chronic disease management • Linkage with national initiatives such as Exercise is Medicine, etc. • Collaboration with FNHIB and linkages with nursing stations to support equitable access

Key Performance Indicators

1. Improved quality and outcomes of primary and community based care
2. Increased consistency in regular access to enhanced local hubs and core local hub services
3. Reduced ALC days; enhanced use of home care and continuity with PCH
4. Expanded capacity for home care – both medical/consultative as well as rehabilitative/restorative (e.g., in-person or virtual home-based care)