

Manitoba's Clinical & Preventive Services Plan

Investing in Better Care, Closer to Home

FINAL REPORT



Acknowledgements

Shared Health, Inc. was mandated to develop Manitoba's Clinical and Preventive Services Plan (CPSP), the province's first five-year plan. This was created in collaboration with clinical providers and health system leaders to improve the delivery of health care across the province. Manitoba is committed to broad system transformation to improve access to care and quality of patient outcomes. This was driven by the clear understanding of the need to plan and deliver health services differently and better.

To support this work, 11 Provincial Clinical Teams, including almost 300 clinical and health system leaders, were engaged to review and analyze reviews and reports, compile and examine leading practices, and make recommendations for new models of care. These professionals brought expertise, local knowledge and experience to the development of the plan. In addition, a number of cross-clinical working groups were focused on ensuring emergency medical services, patient transport, diagnostics and digital health would be coordinated and integrated across and between specialty areas as models of care and patient pathways were developed and refined. This report could not have been prepared without the informed perspectives of clinical and health system leaders across Manitoba and we thank them for their time and commitment to the future of our health system.

Oversight and clinical guidance were provided throughout by an Integrated Leadership Team that included urban, rural and northern representation from each specialty team and the cross-clinical working groups. These leaders devoted their time, expertise and leadership to developing the plan and continue to be leaders in moving our system forward. We thank them for their efforts.

An additional 3,000 individuals and organizations provided feedback and input on core concepts as recommendations were refined and finalized. Stakeholders across Manitoba welcomed Shared Health into their communities and we thank them for their open engagement. Together, we have developed a clear path to improve care for all Manitobans. A path that responds to the needs of patients, families and communities and will improve quality, access and equity of care.

This Plan was supported by Deloitte, in collaboration with Shared Health and the Transformation Management Office.

Table of Contents

Section	Page
Acronyms and Abbreviations	4
Reconfiguring for a Better Future	6
A Provincial System for Health	17
Achieving the Benefits of a Provincial Approach in Manitoba	35
Provincial Transformation Levers	49
Building for the Future	88
Companion Documents	
Report Overview	
Provincial Clinical Team Chapters (11 documents)	

Acronyms and Abbreviations (1/2)

Abbreviation/ Acronym	Description	Abbreviation/ Acronym	Description
ACP	Advanced Care Paramedic	EKG	Electrocardiogram
AFM	Addictions Foundation of Manitoba	EMR	Electronic Medical Record
ALC	Alternate Level of Care	EMS	Emergency Medical Services
ALOS	Acute Length of Stay	ERS	Emergency Response Services
APRT	Advanced Practice Respiratory Therapist	FLS	French Language Services
CCMB	CancerCare Manitoba	FNIHB	First Nations Inuit Health Branch
CCP	Community Cancer Program	GP	General Practitioner
CCU	Cardiac Care Unit	HCA	Health Care Aide
CHF	Congestive Heart Failure	HHR	Health Human Resource
CIHI	Canadian Institute for Health Information	HSC	Health Sciences Centre
CMG	Case Mix Group	ICT	Information and Communications Technology
COPD	Chronic Obstructive Pulmonary Disease	ICU	Intensive Care Unit
CPSP	Clinical and Preventive Services Plan	IERHA	Interlake Eastern Regional Health Authority
CT	Computerized Tomography	ILT	Integrated Leadership Team
DAD	Discharge Abstract Database	IM&A	Information Management and Analytics
ECHO	ECHO Model™	LOS	Length of Stay
ED	Emergency Department	LPN	Licensed Practical Nurse

Acronyms and Abbreviations (2/2)

Abbreviation/ Acronym	Description	Abbreviation/ Acronym	Description
MCLC	Manitoba Clinical Leadership Council	POCT	Point of Care Testing
MH&A	Mental Health and Addictions	PT	Physiotherapy (Therapist)
MHSAL	Manitoba Health, Seniors and Active Living	RAAM	Rapid Access to Addictions Medicine
MIS	Management Information System	RACE	Rapid Access to Consultative Expertise
MRI	Magnetic Resonance Imaging	RHA	Regional Health Authority
MyHTs	My Health Teams	RN	Registered Nurse
NICU	Neonatal Intensive Care Unit	SANE	Sexual Assault Nurse Examiner
NP	Nurse Practitioner	SBH	St. Boniface Hospital
NRHA	Northern Regional Health Authority	SHSS	Southern Health Santé Sud
OR	Operating Room	SLT	Speech Language Therapy (Therapist)
OT	Occupational Therapy (Therapist)	STEMI	ST-Elevation Myocardial Infarction
PA	Physician Assistant	TAC	Trauma Association of Canada
PCH	Personal Care Home	TCU	Transitional Care Unit
PCT	Provincial Clinical Team	TLT	Transformation Leadership Team
PICU	Paediatric Intensive Care Unit	TMB	Transformation Management Board
PMH	Prairie Mountain Health	WRHA	Winnipeg Regional Health Authority

Reconfiguring for a Better Future

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

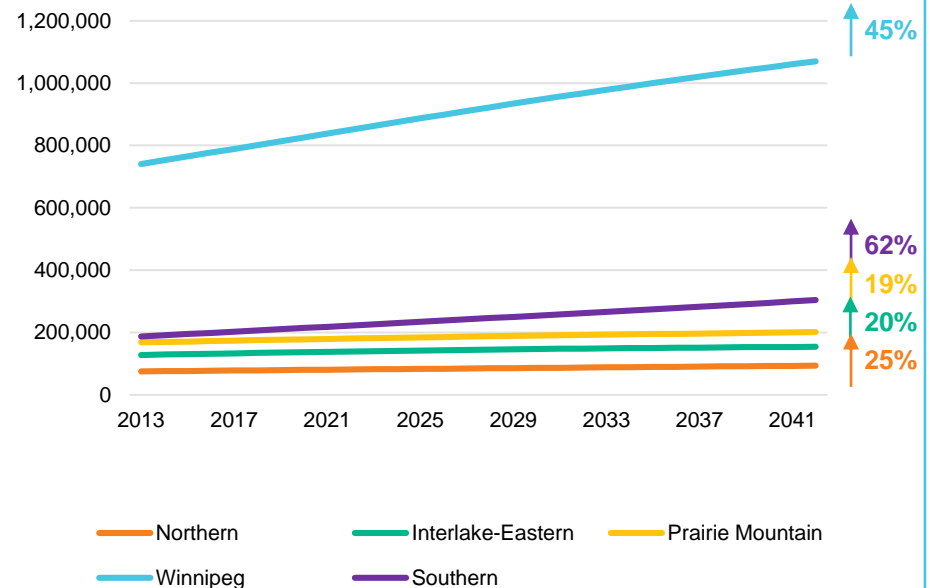
Manitoba's Indigenous population makes up **18% of the population**, the highest of any province in Canada. This population is also younger than the rest of the province



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

Manitoba Population Growth and Projections by RHA



An opportunity to elevate outcomes through reconfiguration

Manitoba is experiencing **variations in health status and clinical practice** across population and geographies. These represent opportunities to improve equity and move to provincial standards of care to elevate outcomes consistently.

Varying Health Status Across the Province

Manitoba is in a position to establish a foundation for the future based on population health needs, putting the needs of citizens at the forefront of decision-making on provincial health resource configuration. A few examples include:

- Manitoba has the **third highest per person healthcare costs** (\$7,354) across the provinces
- **Northern RHA's prevalence of diabetes** (18%) is double the provincial rate
- **Interlake-Eastern RHA** has a higher prevalence of **patients needing a hip replacement**
- 3.4 per 1,000 residents in Manitoba suffered an **acute myocardial infarction** in FY2015-16, with the highest prevalence in the **Northern and Interlake-Eastern RHAs**
- **Prairie Mountain RHA** has a **higher prevalence** of patients that have a **C-section birth** (30% vs. provincial rate of 23%)

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



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.

Stakeholders are aligned on the potential for a better future

Today's achievements will position the province to **realize the CPSP's transformation principles**



Foundational Structures and Capabilities

Over the years, Manitoba has continued to evolve policy, structures, and capabilities across the health system to create a solid foundation to meet the needs of its citizens today and into the future. Examples include:

- Clear regional governance and operations management structures with provincial leadership integration mechanisms for administrators and physician leaders
- Common provincial medical staff by-laws
- Provincial medical credentialing process
- Recent WRHA reconfiguration and consolidation initiative
- Recently completed provincial reports providing a frame of reference for ongoing provincial improvements related to cost effective care delivery, mental health and addiction, and physician services
- Capacity to provide provincial services through the creation of Shared Health



Living Manitoba's Transformation Principles

Through the CPSP process, government, administrators, and clinicians have gained valuable experience and a better understanding of the critical needs and enablers that align with delivering quality, streamlined care to patients and their families. These lessons will carry over to support the CPSP through implementation over the next five years, and beyond.

The provincial plan will support the **CPSP transformation principles**:

1. **Patient-Centric** – Focused on the patient, client or resident as the centre of the care delivery system
2. **Integrated and Effective** – Improved effectiveness through an integrated system that uses innovative models of care
3. **Simple and Clear** – Streamlined pathways and layers required to deliver service, with clear roles, responsibilities and accountabilities for all individuals and organizations
4. **Equitable and Accessible** – Patients have access to services and are not disadvantaged by geography, cultural practices or socially determined circumstances
5. **Sustainable and Efficient** – Fiscal affordability and sustainability of quality of care, now and into the future

Manitoba is ready for change

It will be important for Manitoba to **embrace a future vision for the province** from which to base the CPSP and guide the long-term journey to strengthen an integrated provincial health system.

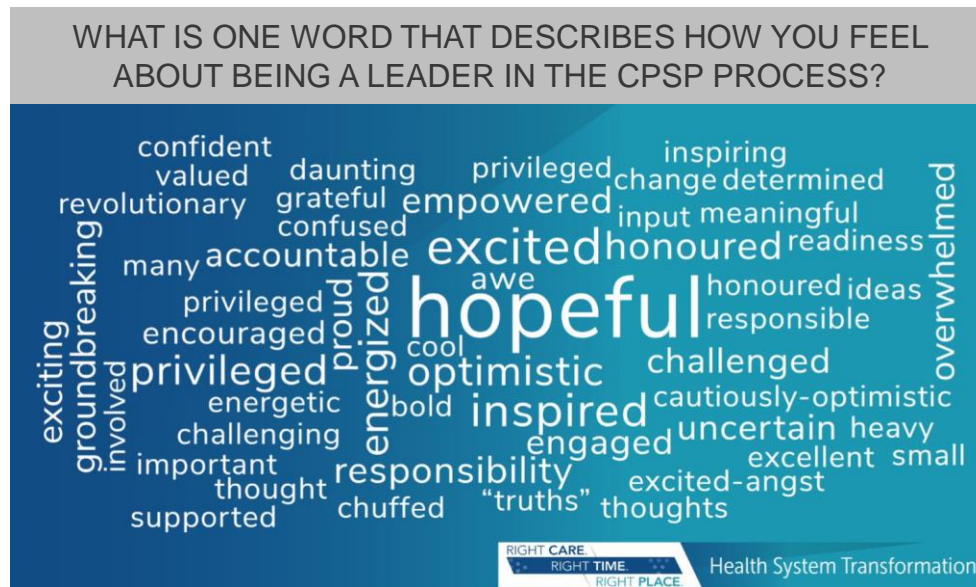


Pulling together Manitoba's strengths and capabilities, evolving provincial structures and policy, and the principles of transformation, Manitoba is well positioned to reconfigure existing resources and services to create an **integrated provincial system**.



Health system leaders participating in the CPSP process demonstrated a commitment to achieving improved outcomes for Manitobans through a reconfigured provincial system and embracing an ideological shift from a provider to a patient perspective.

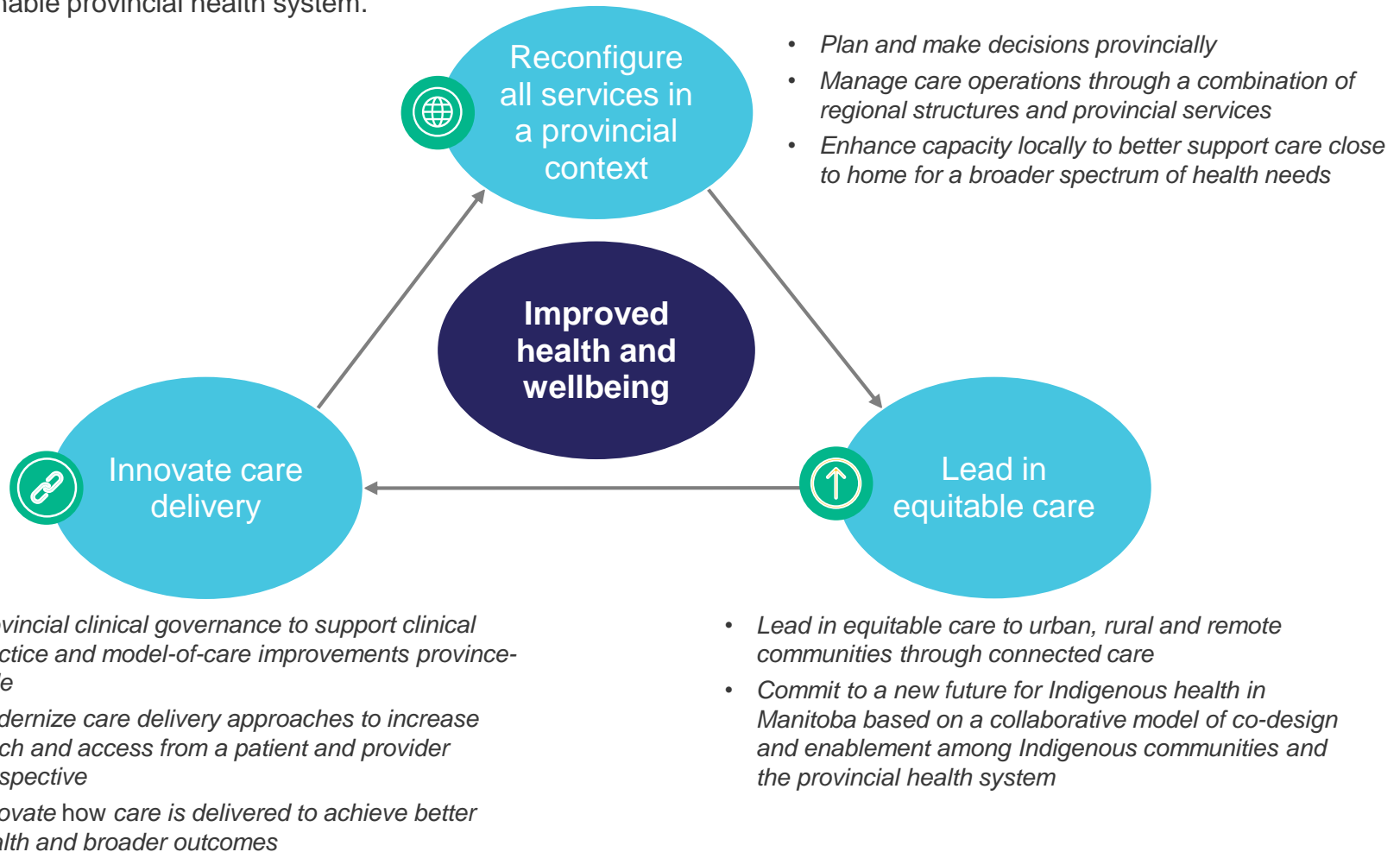
Participating clinical and administrative leaders from across the province, representing all regions and clinical population groups, were surveyed for their perspective on the CPSP process and reflected hope, excitement and optimism about the future.



Survey completed in September 2018

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.



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

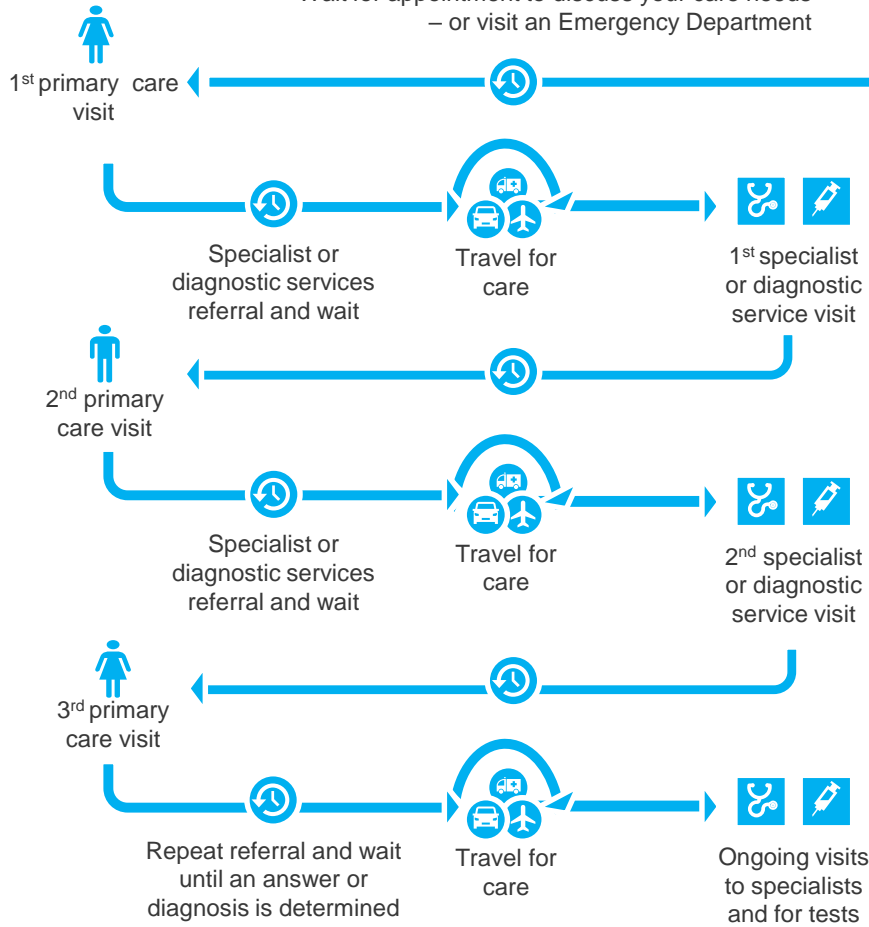
IN THE FUTURE

- 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?

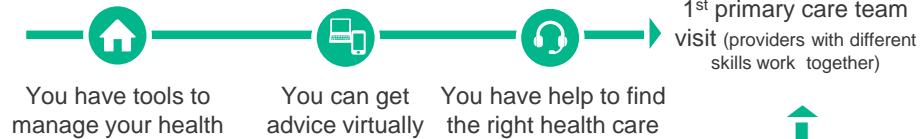
TODAY

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



IN THE FUTURE

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

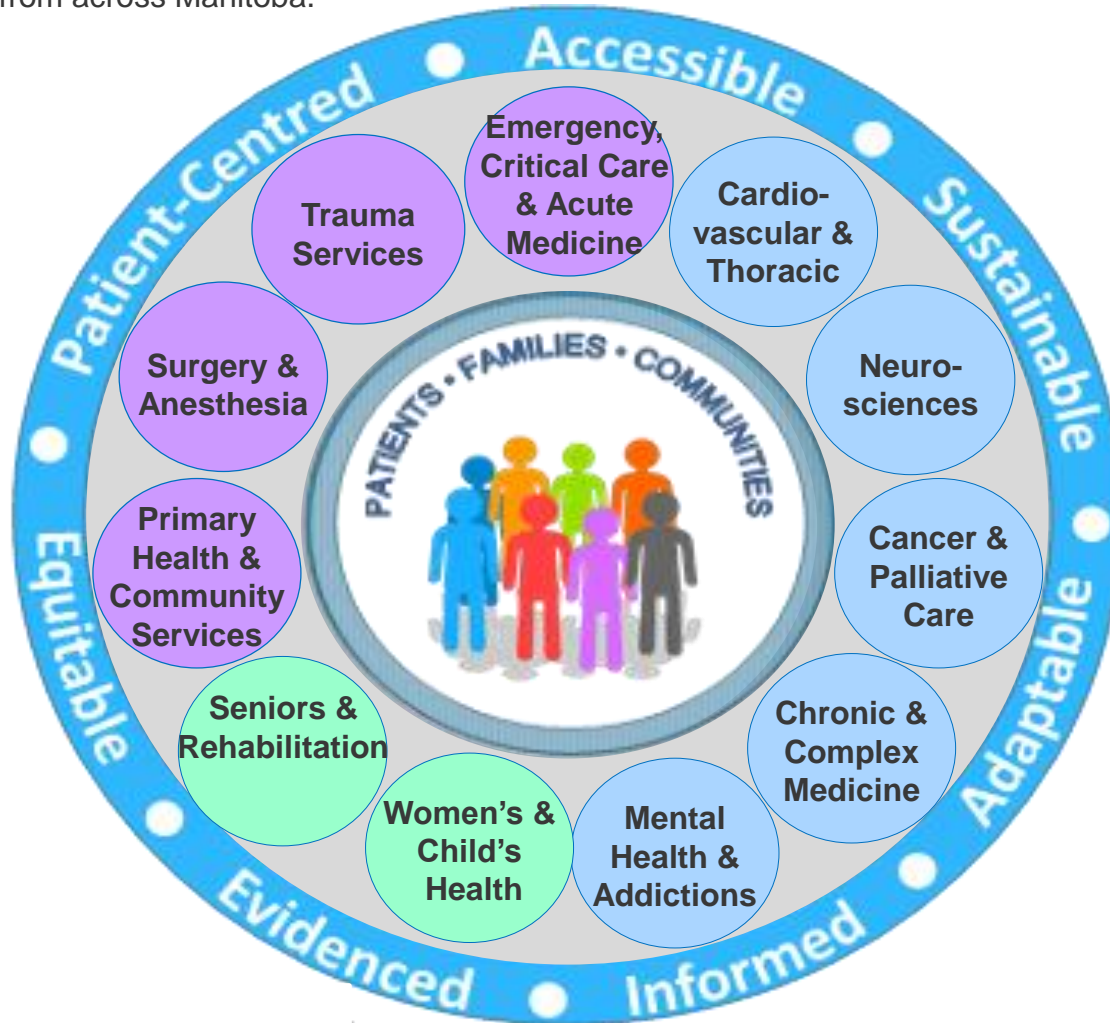
Each step in your care path seamlessly connects back to your local primary health team, keeping them up to date on your care

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



This Clinical and Preventive Services Plan is made in Manitoba and informed by its clinical leadership

All aspects of the provincial health system were planned-for within 11 provincial clinical teams with almost 300 clinical and health system leaders from across Manitoba.



Development of the plan was guided by planning principles

The guiding principles provided a common frame of reference for the planning, stakeholder discussion and future design of the CPSP.



Patient-Centric

Focused on the **patient, client or resident** as the centre of the care delivery system



Sustainable and Efficient

Fiscal affordability and sustainability of quality of care now and into the future



Simple and Clear

Streamlined pathways and layers required to deliver service.
Clear roles, responsibilities and accountabilities for all individuals and organizations



Equitable and Accessible

Patients have **access to services** and are not disadvantaged by geography, cultural practices or socially determined circumstances



Integrated and Effective

Improved effectiveness through an **integrated system** that uses **innovative models** of care

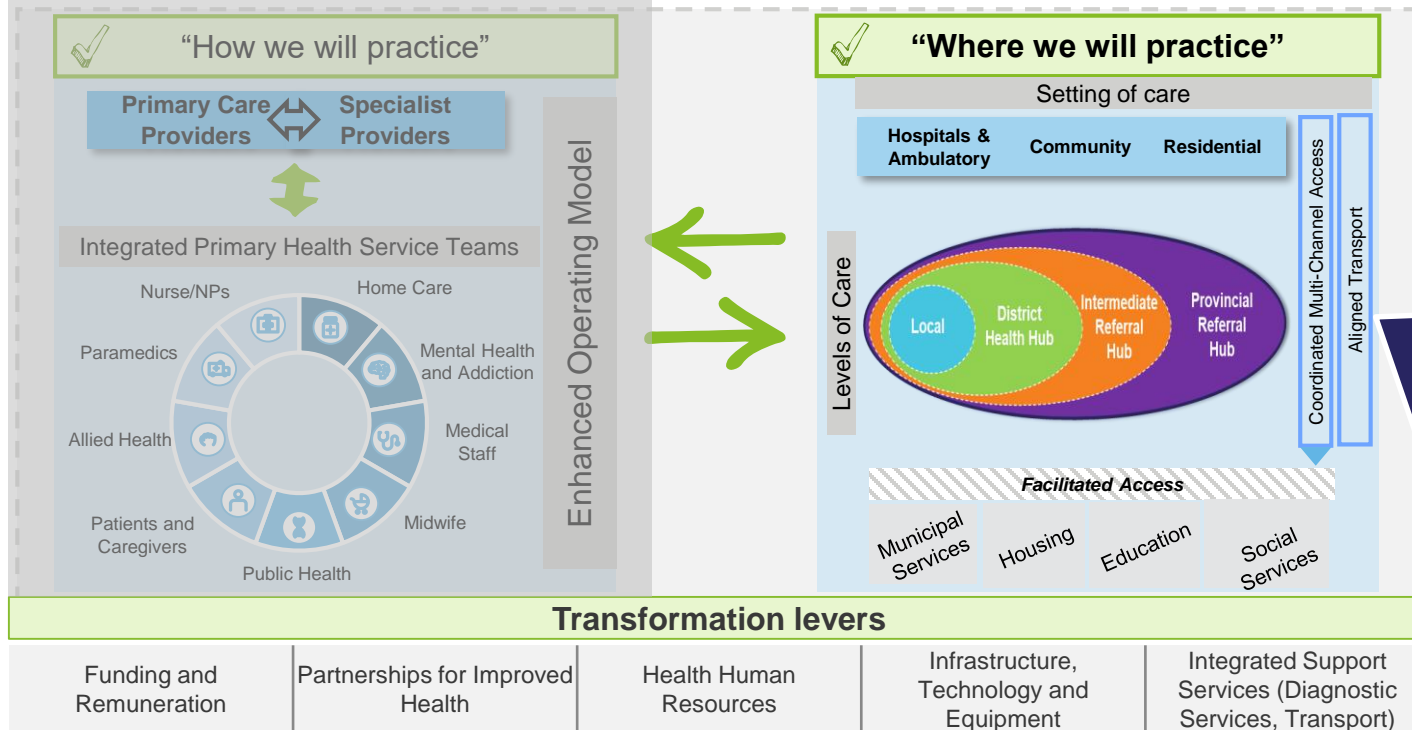
A Provincial System for Health

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

Interdisciplinary Teams Practicing in a New Model



A System That Support Patients and Providers



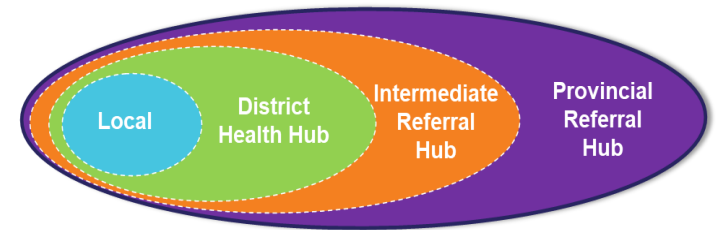
Manitoba currently has more than 75 hospitals, 125 personal care homes, 692 pharmacies, 400 primary care clinics and many individual providers.

To create a cohesive provincial system that is simple for patients and providers to navigate and which efficiently uses system resources, Manitoba needs a provincial model that coordinates access and use of all available integrated clinical services and resources

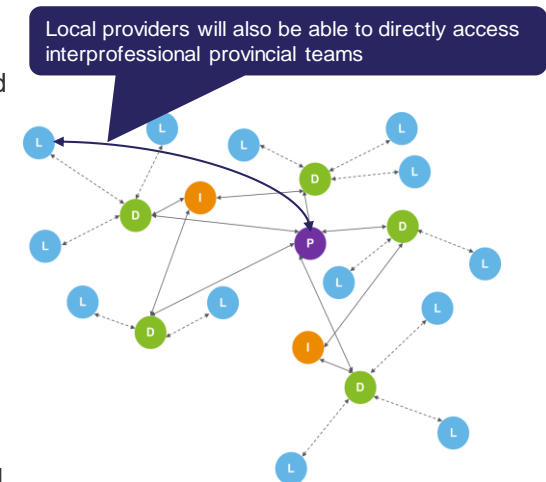
Defining one provincial system with enhanced local capacity and effective access to specialized care province-wide

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



The provincial hub will hold a spectrum of capabilities that are available across the province

The spectrum of capabilities at the provincial hub include:

- HSC as a provincial hub facility
- Shared Health as a provincial resource for key clinical services (i.e., Diagnostic Services, Emergency Response Services, Digital Health) and University of Manitoba as a leading academic centre
- Provincial clinical governance
 - Composed of clinical leaders from across the province, coordinated by Shared Health to monitor the achievements of the clinical plan, inform clinical guidelines, facilitate clinical operations, and inform health human resource planning for the province
 - Provincial clinical governance teams will provide leadership and accountability in defining and adopting provincial clinical standards, pathways and guidelines to drive quality outcomes. Teams will ensure standardized referral networks allow for consistent coordination between levels of the network and will monitor results to determine areas of focus for continuing quality improvement
- Specialty provincial services including:
 - Cancer Care Manitoba
 - Specialized mental health and addictions services (e.g., geriatric mental health, crisis services, detox support/medical withdrawal management)
 - Specialized rehabilitation services (e.g., geriatric rehab, spinal cord injury rehab, amputee rehab, etc.)
- Provincial inter-disciplinary specialty resource teams including:
 - Teams of specialists to provide in-person and virtual consultative support to primary care providers in local, district and intermediate hubs
- University of Manitoba as a critical resource in the training of provincial health human resources, a key partner in the province's health research environment and a service provider through Ongomiizwin Health Services and cross-appointed staff

HSC will uphold its tri-partite mandate of supporting research, academics and delivery of care as part of a provincial hub

Current role of HSC

As an academic health sciences centre, HSC has long served a tri-partite mandate to deliver on research, academic, and clinical needs. It also plays a complex role in continuing to deliver local specialized care within Winnipeg and surrounding regions and is the service provider for specific clinical capabilities, such as major trauma, certain types of specialized rehabilitation, and complex neurosurgery, among others.

HSC provides consultative expertise across the province; however, in the current state this tends to be *ad hoc* and relationship-driven based on individual networks, rather than via a standardized access point for the province.

The future role of HSC

In the network model, HSC will continue to play a key role as the provincial hub for specialized and complex care and will take on an enhanced leadership role to enable the development of capabilities at all levels of the network.

1. Delivery of specialty care, including but not limited to:

- Clinical provider of major trauma
- Comprehensive stroke centre with dedicated stroke unit
- 24/7 ICU and anaesthesiology (FRCPC)
- Level III NICU and high risk obstetrics (jointly with St. Boniface)
- Specialized Thoracic; Specialized Vascular (jointly with St. Boniface)
- Specialty Epilepsy and MS clinics
- Provincial Programs (e.g., renal)
- Specialized surgery/neurosurgery
- Specialized rehabilitation provider (in collaboration with Deer Lodge and Riverview)
- Specialized mental health services
- Specialized paediatric care (Children's Hospital)

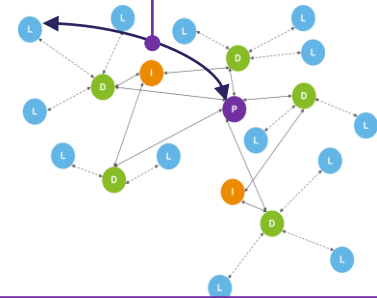
2. Continuing to serve the local population through 24/7 ED and core services (e.g., obstetrics) jointly with St. Boniface

3. Enhancing the clinical capabilities of Local, District, and Intermediate levels of the Network through tele-care and tele-health. HSC has the benefit of having a concentration of specialized professionals compared to a much more distributed resource mix in rural, remote and northern regions of Manitoba.

The future model will be driven by enhanced local area hubs distributed across the province to maximize reach to the broader population. The success of this model requires coordinated pooling of specialist knowledge and streamlined points of access to receive consultative support through tele-health – this is expected to enhance the capability of local providers. It is also expected that HSC will increase its reach through the use of tele-care by virtual and remote monitoring tools that bring specialized care into the patient's home, or as close as possible.

Tele-health - Long wait times and pressures on patients to travel long distances will be reduced through eConsults, which will enable HSC to work with primary health and community providers, including multidisciplinary teams

Tele-care - Limited local resources will be extended, bringing care into the local community through HSC's use of virtual care



Specialty Care Provider - HSC will also serve as provider of acute, complex and specialized needs as part of a provincial hub

The spectrum and distribution of local area hubs across the network will adjust over time as Manitobans' needs evolve and capabilities shift

Distribution of Local Area Hubs Across the Network

- Capacity building at each local area hub will be informed by provincial clinical governance. Operational execution will be managed through the regional structures and provincial services at Shared Health.
- Realignment of capabilities will unfold over a number of years based on a common set of criteria. During the planning stage, an initial set of parameters was applied to assess the system both in terms of local area hubs and their clinical capacity and to predict the magnitude of the shifts. As the plan is implemented, provincial clinical governance will inform the role and clinical profile of hubs across the levels.

Stage 1 – Sizing the Shifts

- A preliminary assessment was conducted during planning to size the nature and direction of capability- and care-delivery shifts that should be pursued in Manitoba to effectively support the province's population. The assessment considered:

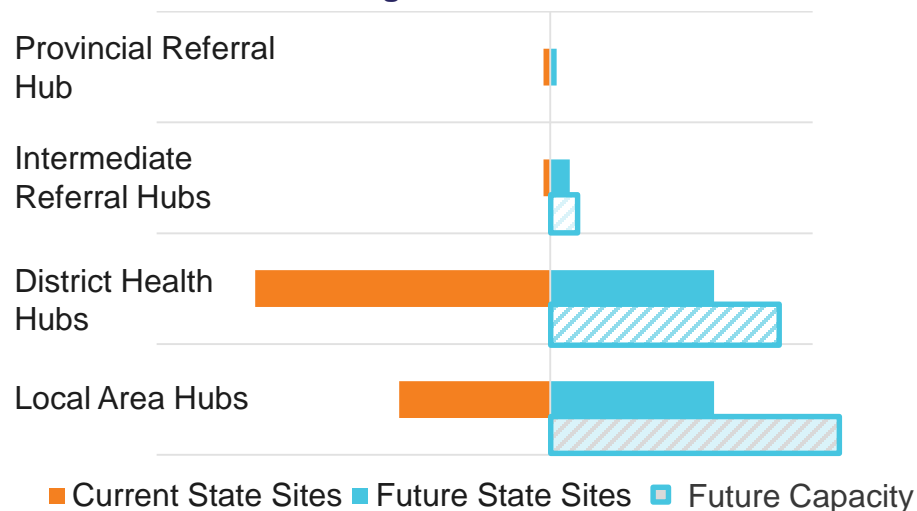
- Level of clinical activity across ED, Medicine, Surgery, Obstetrics, and Critical Care
- Provincial population and associated clinical requirements
- Number and location of PCH beds (where PCH is operationally integrated)
- Existing distribution of facilities, clinical programs, capabilities and geographic dispersion

- Currently, there is significant variance in the nature of district-level care across a wide range of capabilities and volumes:

- Annual emergency department visits range from >42,000 to <500
- Inpatient discharges range from >26,000 to <100






- The variation of care at District hubs causes confusion for patients and providers when navigating the system. This will be addressed in the future system through consistent provincial service standards.

Illustration of the possible spectrum of capability building in local area hubs



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
<i>Low acuity community-based care</i>	<i>Low to moderate acuity community-based and inpatient care</i>	<i>Moderate to high acuity inpatient and medical/surgical care</i>	<i>High acuity/specialty medical and surgical care</i>
<p>Enhanced</p> <p>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</p> <p>Increased focus on prevention and screening with proactive population health management capacity</p> <ul style="list-style-type: none"> My Health Teams, new care models (e.g., collaborative emergency centres in Nova Scotia, advanced care centres in Australia) <p>Core</p> <p>Local primary care providers will be the main point of contact with the health system for most patients (e.g., Home Clinics)</p> <p>Increased focus on prevention and screening with proactive population health management capacity</p>	<p>Core:  Urgent care during set hours for lower acuity patients</p> <p>Enhanced and Intermediate: 24/7 Emergency Department</p> <p>Provincial: 24/7 Emergency Department</p>	<p>General inpatient and ambulatory care with observation and monitoring capabilities, as well as targeted services</p>	
	<p>Enhanced:  Special Care Unit</p> <p>Intermediate: Intensive Care Unit (ICU)</p> <p>Provincial: ICU with specialized capabilities</p>	<p>Core:  Elective surgery, primarily with Family Practice Anaesthesia (FPA)</p> <p>Enhanced and Intermediate: Elective and emergency surgery with FPA or FRCPC</p> <p>Provincial: Elective and emergency surgery with FRCPC</p>	
	<p>Specialist Services may include:  District: Level I Nursery, community cancer care, primary stroke centre, and/or select areas of programmatic focus</p> <p>Intermediate: Level II Nursery, radiation therapy, general rehabilitation, moderate- to high-risk obstetrics and/or primary stroke centre</p> <p>Provincial: Intensive rehabilitation, and specialized mental health services, high-risk obstetrics and neonatal</p>	<p>Provincial Services such as:  Major trauma, thoracic services, comprehensive stroke care, specialty cancer care</p>	

Enhancing services at Intermediate Hubs will shift moderate acuity care closer to home

Stage 2 – Identifying Early Role Realignment Opportunities

- Practitioners across the province will access provincial services through the provincial hub, which is comprised of facility-based care, specialty teams, and provincial services. HSC will continue its role as a provincial facility.
- Early role realignment will focus on shifting care closer to home by re-profiling low-volume District Hubs as Local Area Hubs equipped to deliver enhanced primary and community-based care. This will include enhancing linkages with public health, and ensuring the availability of complementary services including prevention, wellness, and patient self-management of disease. A commitment to **connected care** will optimize in-person capabilities in District and Local Area Hubs with strong virtual care linkages.
- Early role alignment will also focus on building up capabilities for specialist services at Intermediate Hubs. **St Boniface will continue in its role as an Intermediate Hub** providing a comprehensive set of health care services including specialized inpatient care, research & training, specialized vascular surgeries, specialized cardiac care services, anaesthesia care (FRCPC), geriatric medicine, psychiatry, perinatal care, gastrointestinal disease, emergency medicine, palliative care, and neurosciences, among others.
- New Intermediate Hub in Brandon and Intermediate Capacity in the North
 - New Intermediate Hubs will enhance in-person capabilities for higher acuity and specialty services. Intermediate Hubs will participate in and support medical education through UofM. Intermediate Hubs will also have members of provincial clinical resource teams and will provide virtual care for District and Local Area Hubs. For example, Brandon may act as a tele-stroke hub providing consultations to District tele-stroke sites.
 - **Brandon Regional Health Centre** currently has the highest capabilities outside Winnipeg. Key enhancements will ensure that patients from Western Manitoba are not unnecessarily transferred to Winnipeg for care: Necessary enhancements include:
 - ✓ Improving the Intensive Care Unit capabilities and capacity to provide consistent, quality care to high-acuity patients, supported by appropriate multidisciplinary team
 - ✓ Implementing 24/7 internist consultation for the new Clinical Teaching Unit/acute medicine ward
 - ✓ Enhancing emergency and surgical capabilities and diverting associated transfers to deliver care for moderate-acuity trauma
 - ✓ Shifting moderate acuity surgeries from Winnipeg to Brandon
 - **Enhancing the capabilities in the North** by developing enhanced care capabilities to improve access, quality and culturally appropriate care for northern and Indigenous communities. The model for enhanced care in the north should be developed in a collaborative model of co-design with local and Indigenous communities. Key attributes would include:
 - ✓ Enhanced diagnostic supports to inform care, including diagnostic services
 - ✓ Critical care and acute medicine services with remote support from provincial Hub (e.g., tele-ICU)
 - ✓ Improved support for Indigenous Health in the north, in partnership with Indigenous communities
 - ✓ New modes of patient transport for scheduled care (assessment, diagnostics, pre-op, procedures, follow-up) to enable better patient flow to within the North for non-urgent and intermediate care.

Leaders will regularly assess population need and system capabilities based on defined criteria within the framework of the Network Model

Stage 3 – Ongoing Role Realignment

- Over the next five years, **the future role of each facility should be regularly assessed against common provincial criteria to ensure community needs are being met and there is appropriate investment and ongoing operations support.** For example, although residents of Southern Manitoba live in proximity to Provincial and Intermediate Hubs in Winnipeg, high population growth in the region suggests that the development of an Intermediate Hub may be necessary in Southern RHA and should be monitored.
- Criteria for ongoing local area planning to address capability-building, services and realignment should include:
 - Population growth and priority health needs
 - Ability to meet the clinical service standards in the network model (see appendix tables)
 - Proximity to other hubs
 - Need for long-term care
 - Available health human resources to sustain service delivery, support French language service delivery, support provider quality of life, and adhere to provincial clinical standards
 - Appropriate laboratory services, diagnostic imaging, other non-invasive testing, and infrastructure required to support service delivery
 - Non-clinical support services (e.g., laundry, food services)
 - Formal role in medical education with UofM (for Intermediate and District Hubs)
 - Role in French Language Service accreditation or medical education
 - Proximity to Indigenous communities

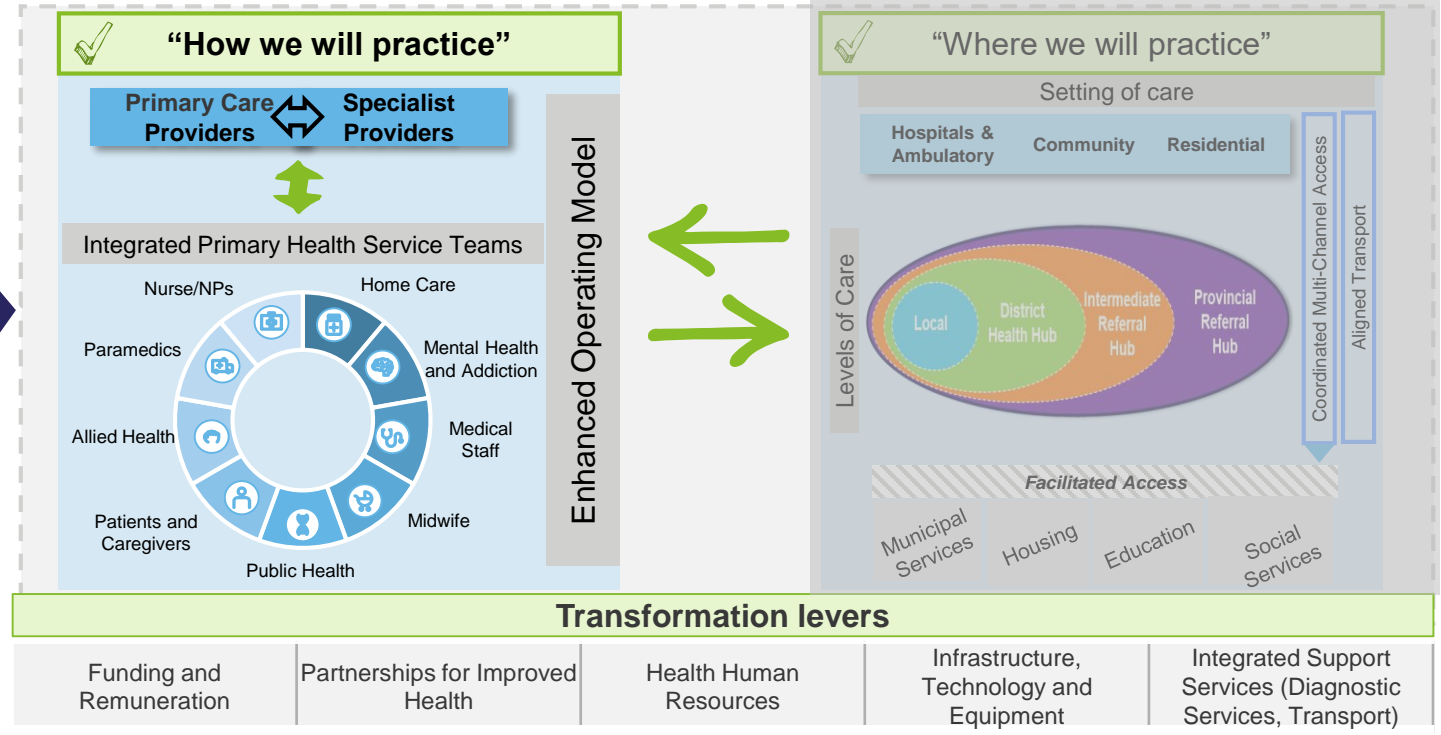
Enhanced team models with bridge building between physicians in community and specialized care will extend the capacity of current providers

Interdisciplinary Teams Practicing in a New Model



A System That Support Patients and Providers

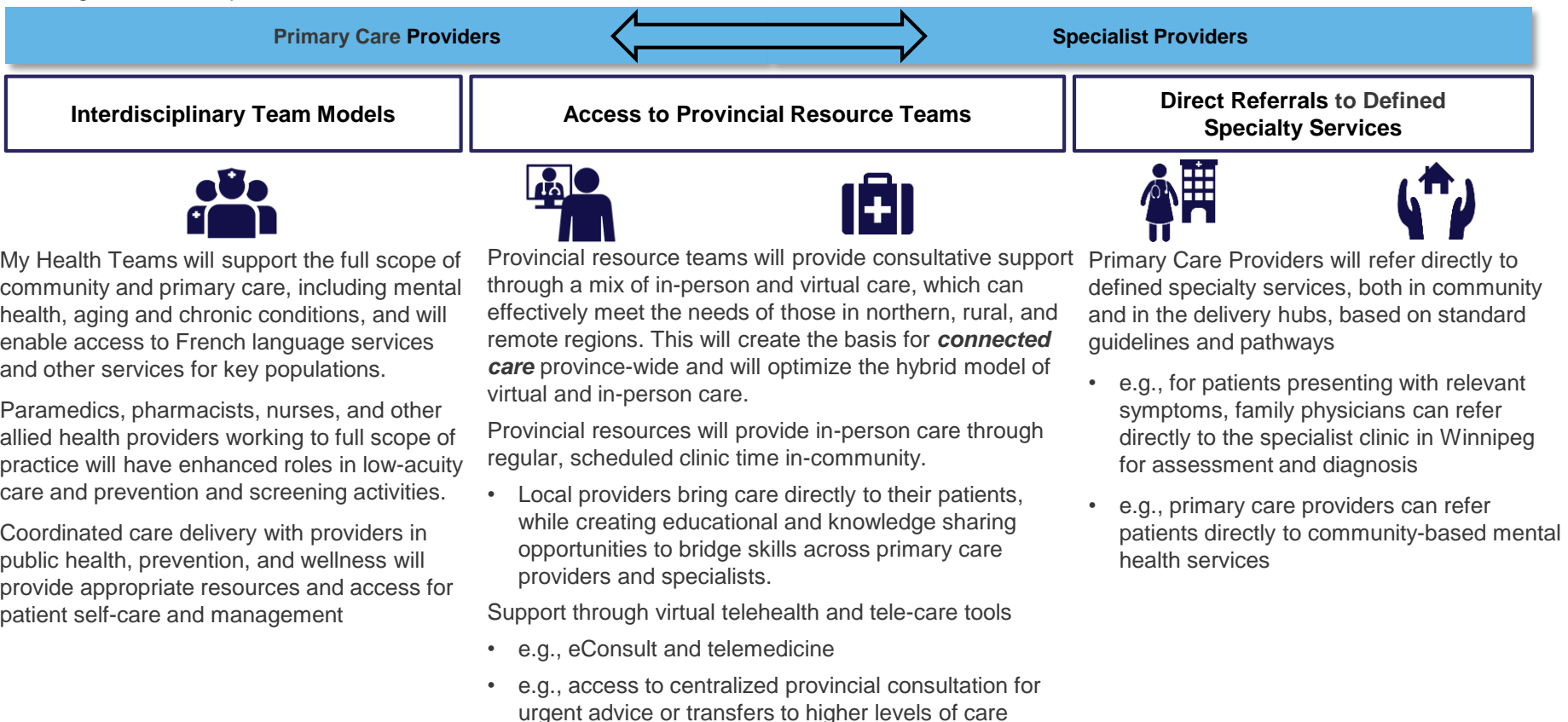
Limited health human resources is a challenge province-wide that can be mitigated by a new model that promotes provider collaboration through the network model



Primary Care Providers will have enhanced access to interdisciplinary teams, prevention and screening, and provincial resource teams

Balancing Manitoba's finite health human resources with the distribution of population and communities across the province is an ongoing planning tension that is not easily resolved. The Network Model will provide the basis to evolve how primary care providers and regulated health professionals working in future My Health Teams are supported by local interdisciplinary teams, prevention and screening, provincial specialized support teams, and direct access to defined specialty services to create more connected, streamlined and comprehensive care.

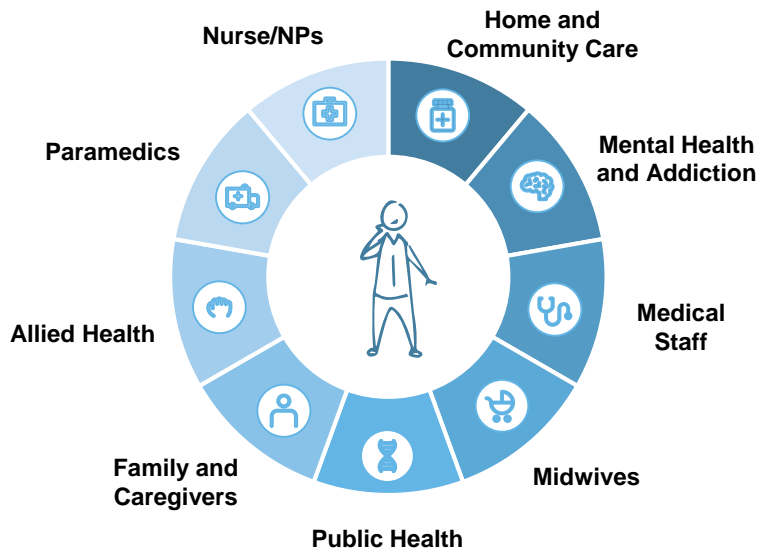
This model is not based on an increase in all practitioners, rather it is reliant upon building capacity within existing human resources. There are areas, however, where Manitoba will need to focus recruitment to close significant gaps to better align with national comparators. For example, the number of psychologists *per capita* is less than half the national rate (20 per 100,000 compared to 51 per 100,000) and access to psychology is a commonly-cited challenge across multiple clinical areas.



Patients will be supported by interdisciplinary teams locally, and empowered with self-care

This new model of care will change the way patients experience and interact with the health system. Interdisciplinary care will wrap around patients to support them in their home and/or community, and to enable patients and families to take greater ownership in their health and well-being. The **connected care** model of hybrid virtual and in-person care includes the involvement of patients and families in proactive health management, navigation and care management.

Integrated Primary Health Service Teams



Future Model Impacts to Patients and Families



Inclusion of family and caregivers on the care team: Patients and their families will be involved in decision-making about their care, have better understanding of their condition and care needs, and ensure that the care plan is aligned with their preferences and expectations.



New knowledge and capabilities to shift from in-facility to care at home/in community: With the use of telehealth and home monitoring, how patients connect with practitioners may differ, while their ability to share current health status and refine care plans will be maintained on a more regular basis

- e.g., increased self-management with post acute therapy through virtual modules for rehab
- e.g., online Cognitive Behavioural Therapy to support virtual models, as an alternate to in-person classes



Enhanced collaborations with different practitioners: Patients and families will receive appropriate care from the right clinicians, with transparent sharing of care plans and goals.

- e.g., Paramedics to assist with urgent treatment of PCH patients with virtual support locally or across the Network
- e.g., Pharmacists to support cancer prevention and screening initiatives in the local retail pharmacy
- e.g., Public health providers to support an increased focus on prevention and screening

Indigenous Health in Manitoba

Key Facts

- Striking health inequities persist between Indigenous/non-Indigenous populations across Canada. These health disparities cut across nearly every major health outcome, health determinant, and measure of access.

Manitoba's Indigenous population is **young and growing**:

- 54% of the First Nations population is below the age of 25 compared with 32% of the provincial population
- The birth rate in Northern RHA (which is 70% Indigenous) is almost twice the provincial rate

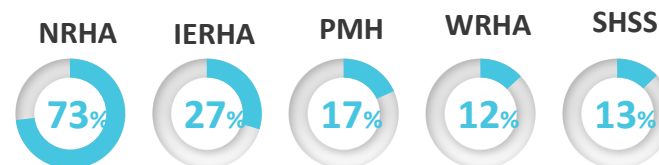
Manitoba's Indigenous population has **high healthcare utilization**:

- Indigenous peoples receive health services through a patchwork of federal and provincial services and coverage
- Up to 40% of urban hospital patients are Indigenous
- Indigenous peoples utilize hospitals and medical services at 2-3 times high frequency than other Manitobans

Key challenges facing the First Nations population include **housing, mental health, and chronic disease**:

- 58.7% of on reserve homes had mould or mildew (almost double the national rate for on-reserve housing). 10.8% of adults living in homes with mould or mildew had asthma compared with 6.3% for those who did not
- Northern RHA has two or more times higher prevalence than the rest of the province for a number of conditions including suicide, diabetes, and hospitalization due to injury

Self-Reported Indigenous Identity

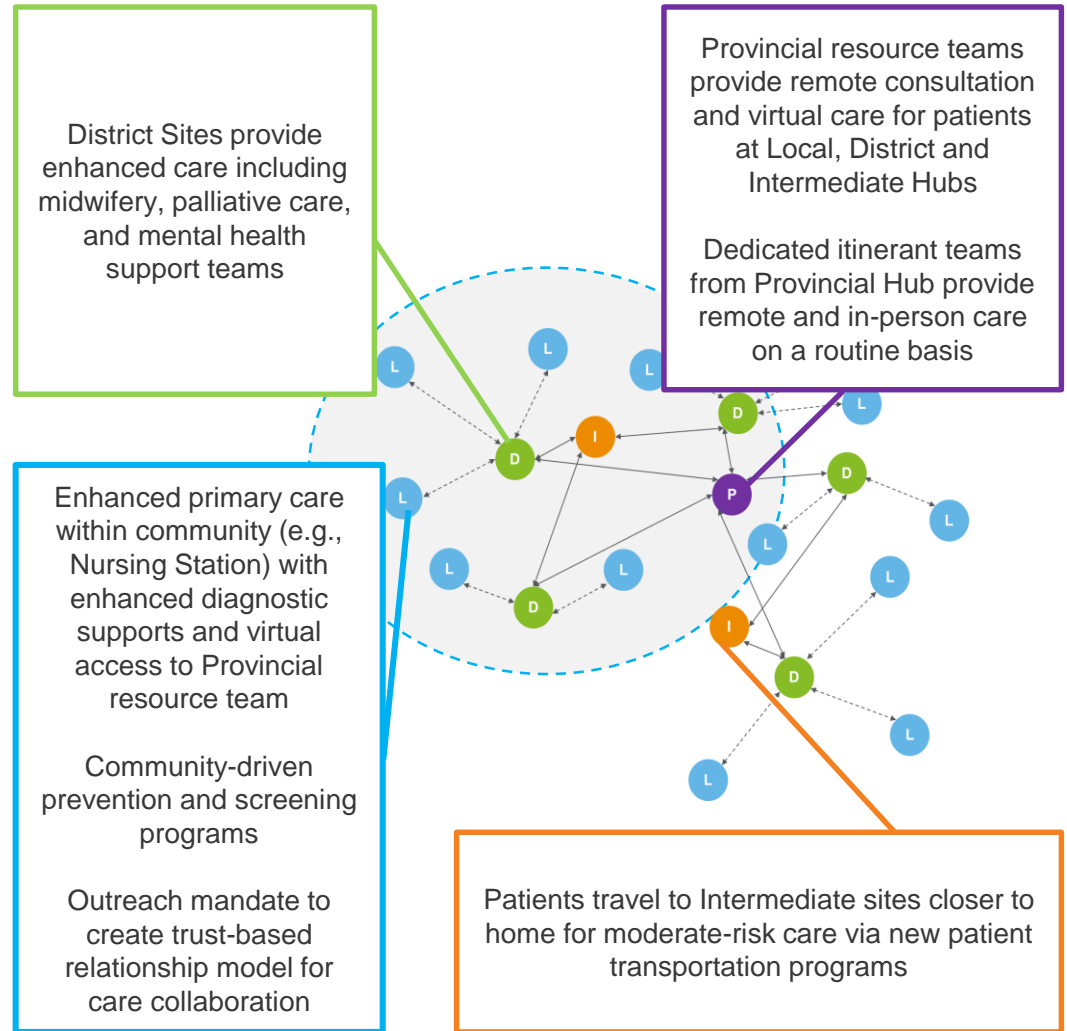


Truth and Reconciliation Commission of Canada Call to Action

- First Nations, Inuit and Metis peoples have Treaty, constitutional and human rights
- Reconciliation requires action to address the ongoing legacies of colonialism
- Reconciliation must create a more equitable and inclusive society through closing the gaps in social, health and economic outcomes
- All Canadians, as Treaty people, share responsibility
- The perspectives and knowledge of Indigenous Elders and Knowledge Keepers is critical

Shared commitment to a new future for Indigenous Health

- The Network Model provides the basis for improved coordination of care, proactive prevention and screening, increased access to specialist care, and reduced travel out of the community for care that can be delivered closer to home
- This can only happen with a shared commitment to a new future for Indigenous health in Manitoba based on a **collaborative model of co-design and enablement** among Indigenous communities
- Key enablers for implementing the model include:
 - **Leading roles for Indigenous communities** and their community health resources
 - Planning and decision-making that is **inclusive of integrated services** to federally-funded communities
 - Incorporating requirements for **rural/remote/northern placements**, as part of the curriculum for learners in the health field
 - Extending specialist and interdisciplinary team member deliverables to include **dedicated itinerant rotations**
 - Implementing **cultural safety training** for all providers
 - Working to address **alignment considerations between provincial and federal policies** and procedures

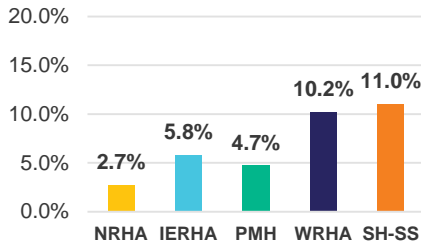


Manitoba's Francophone Population

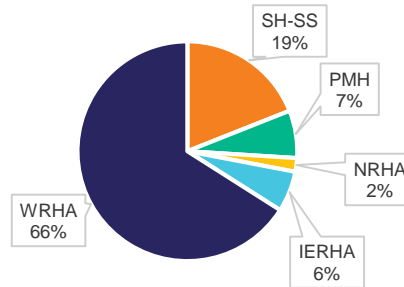
Key Facts

- Manitoba's Francophone community includes those persons whose mother tongue is French as well as those persons whose mother tongue is not French but who have a special affinity for the French language and who use it on a regular basis in their daily life (definition as per *The Francophone Community Enhancement and Support Act*).
- Manitoba's Francophone population is **109,935**

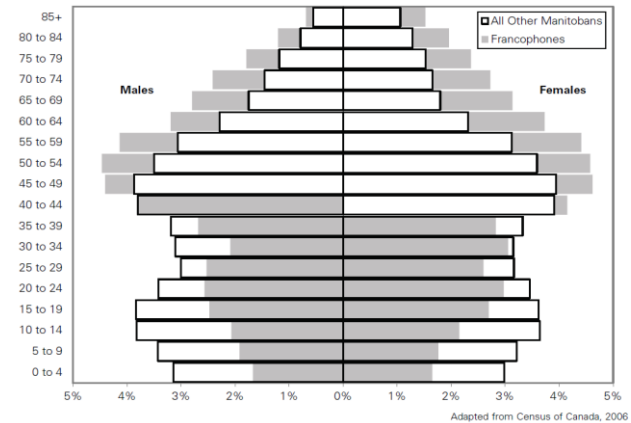
% Francophone population by Region



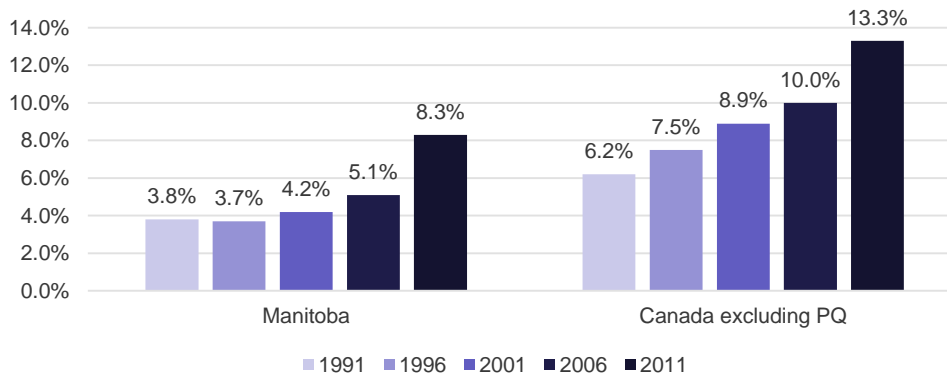
Manitoba Distribution of Francophones



Age and Sex Profile of Manitoba Francophones and all Other Manitobans, 2006



Proportion of French-speaking immigrants in the population for whom French is the first official language spoken



74 %

Of Manitobans who speak French were born in Manitoba



15 %

Were born elsewhere in Canada



11 %

Were born abroad (57% African, 28% European, 9% Asian, 7% Central American)

Coordinated Planning for French Language Services

The Network Model provides a framework for aligning the province's health human resource strategy to serve the Francophone population in rural, urban and northern communities:

L

Local

Access to and delivery of primary care in French at designated sites and community-driven programs. A focus on priority populations identified as the most vulnerable and highest need in the Francophone population: children, seniors, immigrants/refugees, those with mental health conditions and addictions and those needing maternal, acute and palliative care. Designated sites will play a critical role in continuing the training and education of French providers. The highest number of bilingual positions will be distributed within local area hubs organized to ensure critical masses of bilingual professionals in areas of concentrated Francophone populations.

D

District Health Hub

Access to and delivery of enhanced care to the priority populations in designated facilities with support from designated intermediate and provincial hubs. Service models will be built upon existing successes (e.g., Centre de santé Saint-Boniface, Ste-Anne, Notre-Dame-de-Lourdes, St. Claude) in areas of geographic concentration of Francophones. Inter-regional flexibility and innovative models will support access. Designated sites will play a critical role in continuing the training and education for French providers.

I

Intermediate Referral Hub

Access to and delivery of bilingual moderate to high acuity care through St. Boniface Hospital. St. Boniface Hospital supports 85% of Manitoba's Francophone population located in Winnipeg Regional Health Authority and Southern Health-Santé Sud. Intermediate care for Francophone populations province-wide will support quality access in more remote, rural and northern communities.

P

Provincial Referral Hub

Facilitate access to and delivery of French-speaking specialist resources through outreach clinics or the use of digital health tools. Provincial governance teams will provide leadership in the implementation of standards, education and training programs and support coordinated planning. This includes the role of HSC Children's as the provincial hub providing tertiary paediatric services. Creative approaches of clustering Francophone resources within units/service areas will ensure access to critical masses of bilingual providers. Post-secondary educational institutions where bilingual students study, including, the University of Manitoba and Université de Saint-Boniface will continue to support the training of francophone health care providers.

Manitoba is welcoming record numbers of new Canadians

Key Facts



23%

Increase in Manitoba's Immigrant population from 2011-2016



80%

New Canadians in Manitoba reside in Winnipeg



18%

Manitoba's population in 2016 were new Canadians

Manitoba has the **highest per capita rate of immigration in the country** and immigrants arriving in Manitoba are not a homogenous population but represent all world areas, numerous languages, all ages, and a variety of life experiences.

In 2017:

- 14,700 permanent residents chose Manitoba as their immigration destination. This represents 5.1% of total immigration to Canada.
- 20% of these new permanent residents chose communities outside of Winnipeg, a 4% increase from 2016.
- India, Philippines, China, Eritrea, and Nigeria ranked among the top five origin countries for immigrants to Manitoba, representing 62% of all immigrants.

22% of new permanent residents in 2017 were refugees who may face additional barriers to access and have more complex or acute needs.

Key barriers to care for newcomers to Canada include:



Access and orientation challenges

Lack of familiarity with the Manitoba health system can lead to uncertainty with how and when to access care. This can impact a patient's ability to advocate for themselves or their family and their ability to access regular primary care and specialist services.



Language barriers

New Canadians who do not speak English or French on arrival face challenges understanding their care. This can impact system efficiency and effectiveness, quality of care, confidentiality of care and patient understanding and satisfaction. It may also limit participation in health promotion, prevention and screening programs.



Cultural understandings of health

Newcomers may come with a wide range of beliefs regarding health and wellbeing which may result in a different understanding of illness and treatment than their care providers. This can include shame and stigma associated with mental health conditions.

Manitoba programs are leveraging best practices to ensure that newcomer populations have safe and appropriate access to care

Examples of Existing Programs in Manitoba



Language Access Interpreter Services

Language Access currently employs trained health interpreters providing face-to-face, over-the-phone and message relay interpreter services in **over 31 languages in-person and 200+ languages over the phone**. Language Access Interpreter Services filled **99% of requests in 2018/2019 with over 2,000 in-person and over-the-phone services provided per month**.

This provincial service is offered through the WRHA and is now leveraged by other government sectors including housing and justice.

Language Access helps ensure patient safety, quality of care, informed consent, patient access to care, confidentiality, and patient understanding and satisfaction.



BridgeCare Clinic

BridgeCare Clinic was created to address the need for timely, accessible and culturally safe primary healthcare services for recently resettled government assisted refugees in Winnipeg. In partnership with the Language Access Program, the WRHA developed BridgeCare Clinic as an evidence-informed response to the health needs of this underserved population.

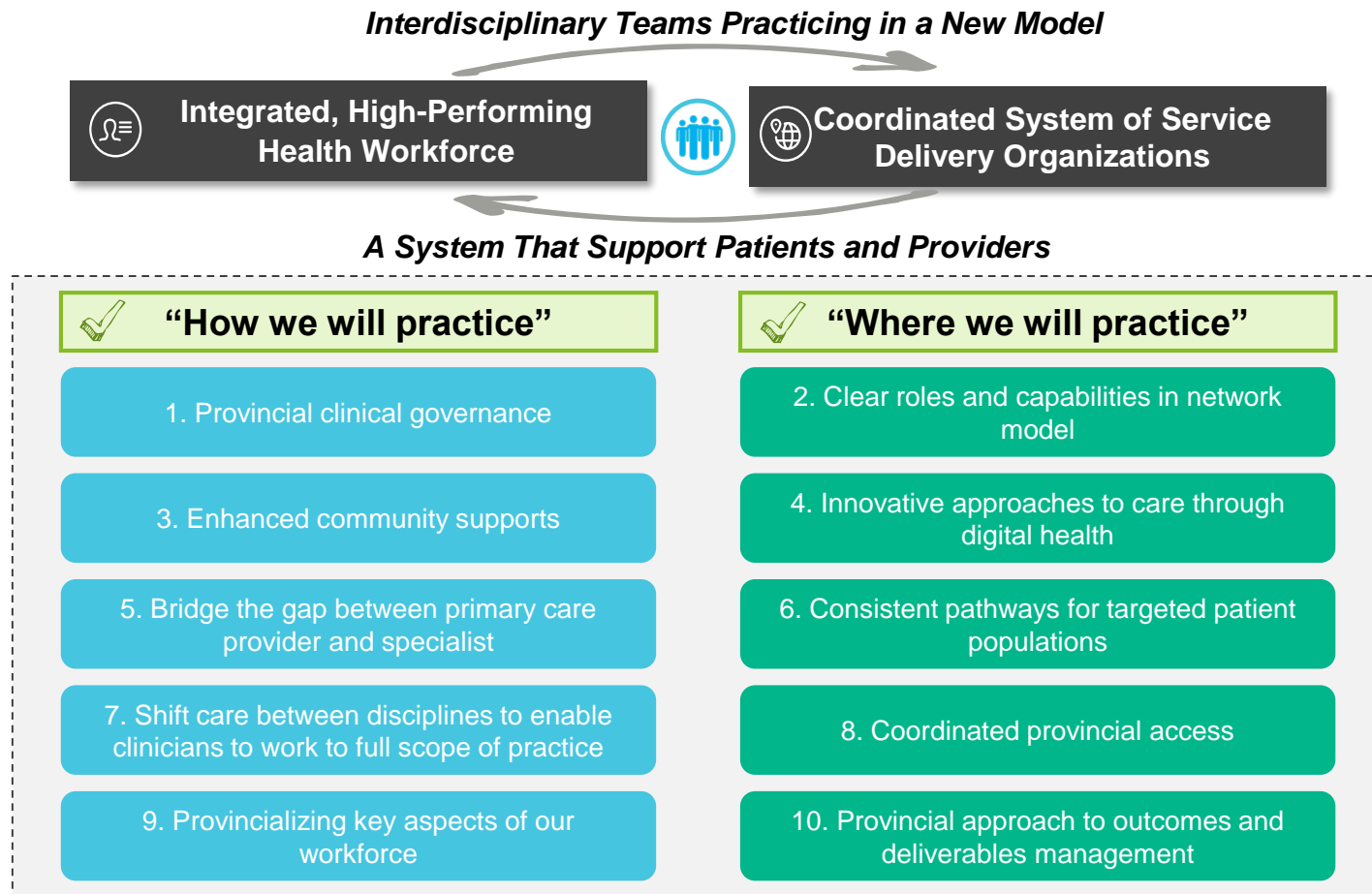
Results:

- Between January 1, 2014 and December 31, 2015 BridgeCare Clinic **received 1,146 new patients**, with a total of **3,769 patients to date**
- Between April 1, 2014 and March 31, 2016 BridgeCare Clinic staff **administered over 5,950 routine immunizations** and **recorded 1,212 referrals out to other services**

Achieving the Benefits of a Provincial Approach in Manitoba

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



Linking the needs of Manitobans to the future health system model

The following template will be used to address each of the ten opportunities on the following slides

High-level description of the core issues

1 | Provincial clinical governance

Clinical governance provide leadership in developing provincial standards, pathways, and guidelines to support consistent practice provincially

Core issue in Manitoba	<ul style="list-style-type: none"> Variability in clinical oversight at a provincial level resulting in variability in clinical practice patterns, a lack of common approaches and fragmented and inconsistent care Inconsistent province-wide standardization, despite multiple initiatives <ul style="list-style-type: none"> The Cardiac program in WRHA plays a leadership role in Manitoba to supporting other RHAs with establishing leading practice standards; however, the program does not have a formal provincial mandate and it is recognized there is opportunity to enhance dissemination of guidelines and pathways The College of Physicians and Surgeons of Manitoba have published standard levels of obstetrics care but there is limited use or implementation of these in planning and service delivery 	<p style="text-align: center;">Reference points</p> <p>Australia Clinical Governance Network</p> <ul style="list-style-type: none"> Multiple Clinical Networks created through the NSW Agency for Clinical Innovation Focused on establishing standards of clinical care, improving clinical practice, and quality monitoring Provided valuable mechanisms for meeting goals and pursuing collaborative interests and a practical approach to addressing clinician engagement in regional implementation of best practices <p>Alberta Provincial Trauma Committee</p> <ul style="list-style-type: none"> Establish to support the development of a provincial inclusive trauma system, emphasizing increased efficiencies, data collection and community Goal of the committee to enhance role of rural centres Outcomes of the all-inclusive trauma system resulted in a 12% reduction in mortality and a decrease in mean trauma patient hospital LOS by 1 days
Nature of change	<ul style="list-style-type: none"> Establish dedicated provincial clinical and administrative groups with representative membership and including academic representatives, to provide leadership and accountability in defining, adopting, auditing provincial clinical standards, pathways, and guidelines to drive quality outcomes Clinical governance works with Shared Health to report on expected quality outcomes for providers, organizations, regions and the province Provincial clinical governance will inform decision-making on sustainability of operations in different hubs and ensure better coordination between hubs through standardized referral networks They will also inform provincial HPE planning driven by the capabilities and competence expected to realize the service standards across the Network Shared Health will support the performance management system to enable clinical governance and will work with regional structures to operationalize and manage provincial guidance 	
Measures of success	<ul style="list-style-type: none"> All hubs following standard pathways and clinical practices Reduced variation in practice Improvement and consistency across quality measures Increase in service provision in currently under-resourced areas 	

Evidence from other areas and jurisdictions to support the new direction

Description of Manitoba's anticipated improvements

Descriptions of results to seek

1 | Provincial clinical governance

Clinical governance teams provide leadership in developing provincial standards, pathways, and guidelines to support consistent practice provincially

Core issue in Manitoba

- Variability in clinical oversight at a provincial level results in variability in clinical practice patterns, a lack of common approaches and fragmented and inconsistent care
- Inconsistent province-wide standardization, despite multiple initiatives
 - The Cardiac program in WRHA plays a leadership role in Manitoba supporting other RHAs with establishing leading practice standards however the program does not have a formal provincial mandate and there is recognized opportunity to enhance the dissemination of guidelines and pathways
 - The College of Physicians and Surgeons of Manitoba has published standard levels of obstetrics care but there is limited use or implementation of these in planning and service delivery

Nature of change

- Establish dedicated provincial clinical and administrative groups with representative membership which includes academic representatives, to provide leadership and accountability in defining, adopting, auditing provincial clinical standards, pathways, and guidelines to drive quality outcomes
- Clinical governance will work with Shared Health to report on expected quality outcomes for providers, organizations, regions and the province
- Provincial clinical governance will inform decision-making on sustainability of operations in different hubs and ensure better coordination between hubs through standardized referral networks
- Teams will also inform provincial HHR planning to meet the capabilities and competencies expected to achieve service standards across the Network
- Shared Health will support the performance management system to enable clinical governance and will work with regional structures to operationalize and manage provincial standards and guidance

Measures of success

- All hubs following standard pathways and clinical practices
- Reduced variation in practice
- Improvement and consistency across quality measures
- Increased service provision in currently under-resourced areas

Reference points

Australia | Clinical Governance Network

- Multiple Clinical Networks created through the NSW Agency for Clinical Innovation
- Focused on establishing standards of clinical care, improving clinical practice, and quality monitoring
- Provided valuable mechanisms for meeting goals and pursuing collaborative interests and a practical approach to addressing clinician engagement in regional implementation of best practices

Alberta | Provincial Trauma Committee

- Established to support the development of a provincial inclusive trauma system, emphasizing increased efficiencies, data collection and community
- Goal of the committee is to enhance the role of rural centres
- Outcomes of the all-inclusive trauma system resulted in a 12% reduction in mortality and a decrease in mean trauma patient hospital LOS of one day

2 | Clear roles and capabilities in network model

Provincial services aligned to the Provincial, Intermediate, District and Local Area hubs of the Network

Core issue in Manitoba

- Variation in capabilities and resources of Manitoba's health facilities resulting from the lack of a provincial plan
- Inconsistency in available services offered across sites of similar profile
 - Inconsistent and unpredictable hours at many emergency departments, frequent patient transfers for standard diagnostic testing
- Variable competencies and accountabilities in the roles of similar providers across regions
 - Different nursing scope of practice for nurses in the north vs. Winnipeg and inconsistent use of advanced practice paramedics across regions
- Limited awareness of available resources outside Winnipeg
 - Lack of awareness of capabilities and resources conducting Heart Failure Clinics

Nature of change

- Clinical services across the province will be aligned to the Network model (i.e., Provincial, Intermediate, District, Local) to facilitate optimal flow of patients and to build capacity in select areas to provide care closer to home
- Defined minimum clinical capability, team models, patient transitions, and clinical supports (EMS, patient transport, diagnostics) for each level, including pathways that connect across the Network
- Align education and training programs with clinical shifts to support areas that will be enhancing the services they provide
- Provider roles will be clearly defined to maximize scope of practice with an initial set of service standards and role definitions for each clinical domain
- Capabilities will be enabled through a robust **connected care** hybrid model of in-person, virtual, and self-care that promotes prevention
- Performance monitoring will enable provincial governance networks to better understand areas where more support is required to align with provincial standards and expectations

Measures of success

- All hubs follow standard pathways and clinical practices
- Reduced patient transport to Winnipeg
- Reduced inflow/outflow ratio of where patients receive care (e.g., more patients receiving care in their home region)

Reference points

BC | Levels of Care for Maternal, Newborn, and Paediatric Services

- Standardized levels of care for specialized units
- Includes human resource expectations and services at each level
- Aims to provide equitable access to timely, high quality, evidence-based care

Canada | Community Hospitals as Health Hubs

- Smaller community hospitals build on their unique strength of relationships in the community through local hub models
- Local hub model of health planning, funding and delivery in rural, remote and northern communities

UK | Transforming Community Neurology

- Three tiered model defined the contribution of multi-agencies involved in neurological care
- Focus is on locally provided, integrated care that is organized around the patient

3 | Enhanced community supports

Build capacity in primary health and increase use of digital enablers to reduce patient transfer to Winnipeg

Core issue in Manitoba

- Unsustainable service operations to support the variable distribution of resources across the province
- Challenge for Indigenous communities to equitably access services
 - Indigenous communities have significantly higher rates of hospitalization for chronic Ambulatory Care Sensitive Conditions, relative to the provincial rate
- Variable ALC rates across the regions for similar type services
 - ALC LOS for chronic condition admissions range from 11% - 33% across RHAs
- Variable access to providers who can provide prevention, rehabilitation, and post-acute care in their local communities
- Lack of consistent rehabilitation support available through home care resources

Nature of change

- Transform the provincial home and community care model to ensure consistent enhanced services across the province. This includes alternate HHR models such as consistent locum rotations and additional recruitment of providers where critical mass and population needs exist
- Build capacity in local resources to manage the post-acute needs of patients closer to home, including for Indigenous communities
- Leverage telehealth to expand clinical capabilities locally and enable consistent communication between local providers and expertise in District, Intermediate and Provincial Hubs. The **connected care** approach is a hybrid virtual and in-person care model for all communities.
- Establish virtual tools to support patient and families to prevent and self-manage care
- Enhance the span of primary health to include in community support for low to moderate health and addictions, health aging, prevention, and chronic disease management
- Engage public health and community support services into the My Health Team model more consistently to advance health promotion, prevention and screening

Measures of success

- Increase in access to home and community care post-discharge
- Increased access to home and community care post-discharge
- Reduced proportion of patients paneled for long-term care
- Increased use of itinerant teams to provide specialized care to rural/remote communities
- Reduced average LOS and ALC LOS

Reference points

BC | Home is Best

- Provides home care support services to enable individuals to live safely at home, particularly for seniors who are waiting for LTC placement
- Resulted in a 30% decrease in acute care use, and a 25% reduction in emergency department visits

Winnipeg | Community Stroke Care

- Centralized service for home care and early supported discharge for Stroke Rehab Services
- Community reintegration is a key element of the stroke care continuum
- Decreased average LOS by 16 days from FY 06/07 to FY 16/17

USA | Specialized Case Management and Home Care for Early Discharge

- Multidisciplinary approach used to promote earlier discharge of infants from intensive care (i.e., partnering with paediatric home care company)

4 | Innovative approaches to care through digital health

Provincial implementation of digital health enablers to support increased access and equitable care delivery

Core issue in Manitoba

- Sub-optimal drivers that result in patient travel to Winnipeg – inefficient workflow processes to using Telehealth platforms, challenges with sharing patient information, and variability in quality of diagnostic images across facilities – which can also result in duplication of tests and assessments
 - 19% of patient transfers in the province were for diagnostic testing (e.g., x-ray, ultrasound, CT scan)
- Limited resources in select practitioner roles to match patient demand, particularly in rural and remote communities
- Variability among clinical areas in adopting telehealth capabilities consistently to bridge geography distance for residents
 - Practitioners from the Cancer program generate the highest utilization of telehealth by far relative to other clinical areas

Nature of change

- Implement common provincial information platforms and dataset to support the flow of information and create opportunities for advanced analytics for system planning
- Introduce telecare tools (e.g., tele-homecare) to support remotely delivered patient care and self management
 - Telecare tools will help improve patient satisfaction and enable shifts of care closer to home including the early identification and intervention of health needs
 - Home or community based programs will offer more intensive virtual health counselling and remote monitoring while self-management tools will enable self-care and reduced reliance on regulated professionals
- Leverage telehealth/Virtual Care tools such as eConsult and eReferral to allow providers to learn and communicate in a more streamlined, accessible and consistent manner to promote care closer to home and optimize a more connected patient experience
 - These tools should be consolidated and scaled provincially to promote consistency of information and alignment of processes
- Address digital information sharing barriers across provincial and federal jurisdictions

Measures of success

- Increased use of digital tools including telehealth (for clinical use), tele-home care, eReferral and eConsult
- Reduced patient transport to Winnipeg
- Increased number of patients with chronic conditions using self-monitoring tools

Reference points

Canada, US, UK | Sensory Technologies eShift Clinical Service Model

- Cascading delegated model which enables clinicians to remotely monitor, assess and direct care in the home through smartphone based tools to multiple technicians delivering bedside care
- Reduction in unnecessary hospital readmissions from 25%-45% to 1%-9%

Global | Tele-ICU

- Tele-ICU provides 24/7 virtual clinical surveillance and support with the bedside team through multiple technology components

Ontario | Telehomecare

- In collaboration with primary care providers, nurses remotely monitor and report on patients health status
- Reduced hospitalizations for CHF patients by 66% and COPD patients by 64%

5 | Bridge the gap between primary care provider and specialist

Increase collaboration and communication between providers to improve continuity of care

Core issue in Manitoba

- Inconsistent collaboration and integration between primary care providers and specialists across regions and clinical areas
- Inconsistent access for primary health providers to consult specialist expertise
- High volume of avoidable transfers and long wait times to access specialists
- Inconsistent pathways for specialists to repatriate back to primary health, post acute phase
- Lack of clarity for primary health providers in supporting care for complex patients

Nature of change

- Defined levels of care will clearly outline capabilities of local, district, intermediate, and provincial hubs, which will drive the service standards and support for primary care providers and specialists in a shared care model
 - This will result in practice changes among providers and impact expected physician deliverables. The initial set of service standards for each clinical area is outlined in the appendix.
- Align training and education among physicians, PAs, NPs, allied health and other clinicians across levels of the Network to reinforce alignment to standard practices
- Extend dedicated itinerant specialist models with a scheduled travel rotation to support local and district teams
- New models of care will support ongoing collaboration and information sharing between providers along the continuum of care (e.g., virtual round for ICU patients with a centralized function that enables sharing of results; eConsult platforms that enable image views for urgent and non-urgent advice, provincial consultation service for emergency care)
- Common provincial digital tools will support flow of information and communication between providers

Measures of success

- Reduced patient transport to Winnipeg
- Reduced inflow/outflow ratio of where patients receive care (e.g., more patients receiving care in their home region)
- Decreased wait times for specialist care
- Increased adoption of inter-disciplinary practice

Reference points

WRHA | Rapid Access to Consultative Expertise Model

- Provides a central call number for primary health providers to access specialist expertise to support patient care
- BC realized that 32% of calls avoided ED visits and 60% of RACE contacts avoided face-to-face consults

Ontario | eConsult

- Primary care providers to submit a non-urgent, patient-specific questions to a specialist
- Includes relevant diagnostic tests, images, photos or letters
- Improved access with a median response within 0.8 day
- Over 60% of cases did not require face-to-face specialist visits

New Mexico | Project ECHO Model

- Facilitates collaboration between primary care providers and specialists by bringing rural providers and disease specialists together online to co-manage chronic disease patients

6 | Consistent pathways for targeted patient populations

Implement standards to reduce variability of care for target patient populations

Core issue in Manitoba

- One in five Manitobans have medically or socially complex care needs and/or are frequent users of health services
- Inefficient and complex pathways for these high complexity patients result in variations in access and outcomes (e.g., frail seniors, mental health and addictions, complex and chronic conditions, palliative care)
- Manitoba's Indigenous population has poorer health outcomes due to systemic racism, including jurisdictional barriers to care – 73% of Northern RHA's population is Indigenous, where the rate of diabetes is double the provincial average
- Inconsistent access to services in French for Francophone patients

Nature of change

- Based on national and provincial standards, provincial clinical governance will inform and promote standardized pathways to be adopted by all practitioners
 - An initial set of pathways and service standards has been developed to accelerate the implementation
- A commitment to innovative approaches and alternate modes of care will empower clinical leads to support local practitioners to deliver streamlined care, including advice for lower-resourced communities
 - Regulatory changes or medical directives will enable paramedics, NPs, and nurses to order and administer targeted tests and treatments
- Shared care interdisciplinary models with enhanced prevention and primary care
 - As an example, Winnipeg-based specialized rehab team to provide ongoing follow-up, assessment and education to local teams (My Health Team, Home Care), as well as directly to the patient
- Work collaboratively with other Provincial and Federal entities to plan for optimal and coordinated patient care, to inform complementary services that will be provided to populations that cross jurisdictional boundaries
- The Shared Health website will house provincial standards and pathways for practitioners to access, including when and to whom to consult/refer
- Ensure appropriate care for targeted populations including Indigenous cultural competency and access to services in French for designated sites and programs

Measures of success

- Increased access to prevention and screening programs for targeted populations including increased cancer screening for Indigenous populations
- Increased patient satisfaction (e.g., proportion of people dying in their preferred location)

Reference points

CA | Acute Care for the Elders Units

- Enhanced care for older adults in specially designed hospital units
- Care delivered by interdisciplinary teams including geriatricians and advanced practice nurses
- Length of stay decreased from 7.3 days to 6.7 days, while maintaining functional abilities and not increasing hospital readmission rates

UK | Marie Curie Delivery Choice Model

- Supports palliative patients to be cared for in their place of choice
- Offers end-of-life care coordination centres, an out-of-hours telephone line and discharge in-reach nurses
- Patients in the program were 30% less like to die in hospital or have an admission or ED visit within the last 30 or seven days of life

USA | Indian Health Services

- Health services provided to American Indians and Alaska Natives to ensure culturally accessible services

7 | Shift care between disciplines to enable clinicians to work to full scope of practice

Alternate modes of care to expand scope of practice for select providers to provide care closer to home

Core issue in Manitoba

- Inconsistent distribution of provider resources across the province – not all regions have practicing midwives and 60% of midwives in the province work in Winnipeg
- Variation in professionals practicing at their full scope
- Primary health and specialists provide low-risk care that could be managed by other providers (e.g., allied health, nurse practitioners, EMS)
- Financial incentives are not aligned with models of care that promote inter-disciplinary team practice

Nature of change

- Providers (e.g., physician assistants, nurse practitioners, advanced practice paramedics) work to full scope of practice and deliver care closer to home including prevention services
- Alternate models of care and policy shifts will support this transfer of care accountability
- Shared care models and interdisciplinary teams will improve access to different types of skillsets relative to the traditional primary physician
 - Advanced practice physiotherapists delivering rapid access assessments for neurology and other clinical areas at district facilities to provide enhanced care for patients
 - Community pharmacists supporting health prevention and promotion (e.g., smoking cessation, immunization)
 - Midwives embedded in My Health Teams for obstetrical deliveries and to provide pre/post-natal care
- Consistent use of digital health as a first choice in care delivery will allow for the delivery of timely, efficient care to all Manitobans

Measures of success

- Increased number of professionals working in advanced/enhanced roles (e.g., advanced practice roles)
- Increased recruitment and retention of providers to lower resourced areas
- Optimal service provision by provider type
- Decreased wait times for specialist care

Reference points

Nova Scotia | Expanded Role of Paramedic

- Expanded roles to include blood pressure checks, wound care, falls prevention programs, blood drawing services, and others
- Reduced average number of visits to the ED by 23% since the program began

BC | Midwifery Model of Integrated Care

- Midwives work in small groups to share call and provide 24-hour availability care
- Offer services in clinics, offices or client's homes, including in rural and remote communities

United Kingdom | Emergency Care Practitioner

- Extended clinical skills for paramedics, NPs and others to respond to urgent and non-urgent care needs in the community
- Increased number of discharges home and reduced ED visits and hospital admissions

8 | Coordinated provincial access

Provincial system for referrals and intake to ensure equitable access to services, specialists, interdisciplinary team members, and resources across the province

Core issue in Manitoba

- Long wait times and inequities in access to targeted services
 - e.g., number of patients waiting for a surgical spine consult varies by surgeon from 150 to 850
- Inappropriate use and access to specialty services located in Winnipeg
 - e.g., newborns requiring Level I or II nursery services being transferred to Level III NICU services in Winnipeg
- Referral patterns based on relationships and individual provider awareness of services available which can result in repeated requests for consults to reach the most appropriate advice
- Lack of transparency on available specialist capacity across regions

Nature of change

- Shift from one-to-one physician referrals to a transparent, centralized service where access to services, specialists, interdisciplinary team members and resources will be supported by a common platform enabled through evidence based clinical decision and triaging tools
 - Apply lessons learned from models such as the N60 pathway for cancer-related Thoracic referrals and WRHA hip-and-knee centralized model
- Physicians, PAs, NPs, and other clinicians will directly refer patients to a defined set of services, based on provincial service standards
- Shared Health will support and oversee the platform that coordinates referrals and resource access
- Specialists will move away from personal wait times tracking to pooled approach, which reflect both clinical decision making and patient choice.
- Enablement of eConsult, eDiagnostic, eTreatment planning will support the provincial access model

Measures of success

- Increased use of centralized referral programs
- Reduced time to specialist consult

Reference points

BC | Provincial Maternal Newborn Transfer Network

- Supports critically ill newborns, children and women requiring maternal/fetal care through coordinated operations
- Perinatal health professionals use a no-delay single number to call to access consultations, triage support and transfer coordination

Ontario, WRHA | Central Intake Assessment Centres (CIAC)

- Ontario offers Central Intake and Assessment Centres for elective Hip and Knee replacement surgery
- This multidisciplinary model is used to screen patients to appropriate care based on individual patient need
- Wait times for assessment were 4 weeks or less and 52% of referrals did not require surgery

Australia | Rapid Access Chest Pain Clinic

- Primary care physicians refer directly to clinic where patient receive a single visits and a telephone follow-up call
- Reduced mean wait times from 44.4 days to 11.2 days

9 | Provincializing key aspects of our workforce

Integrated provincial system to ensure equitable access to care across the province

Core issue in Manitoba

- Limited availability of specialists, most of whom are based in Winnipeg
- Challenges in the recruitment and retention of physicians, nurses and other allied health providers to rural and remote communities
- Limited awareness of available resources and capabilities to support patients outside Winnipeg, which can result in unnecessarily long stays in urban centres

Nature of change

- Provincial interdisciplinary teams will provide consultation support province wide based on virtual provincial teams of specialists
- Specialized services and personnel will be accessible through dedicated in-person visits or virtual consultations in the community
 - Trauma specialists in Winnipeg will conduct simulations in remote communities
 - Use of a hybrid FRCPC/FPA model to enable district and intermediate surgical care
 - Specialized allied health teams to provide virtual support to primary care provider teams in District and Local regions to better manage children with complex and developmental needs
- Working with academic centres such as the University of Manitoba, provincial resources to support education and skill-building in the community, including for Indigenous communities
 - Advanced practice paramedics to take on roles in prevention and screening, chronic disease management and support for healthy aging in community

Measures of success

- Decreased wait times for specialist care
- More efficient distribution of HHR across the province to support the shifts in service provision location

Reference points

Manitoba | Ongomiizwin Health Services

- Itinerant care model brings specialist services to remote communities
- Model has resulted in increased access to care with reduced patient travel, improvement in outcomes and reduction in unnecessary tests
- In 2017/18, OHS provided 261 specialist visits to communities in Manitoba involving more than 5,000 patients

Ontario | SickKids Telemedicine Program

- Connects the specialized healthcare team with patients and healthcare providers across the province
- Increased access to medical specialty consults, reduced travel time for patients
- Ensured continuity of treatment and reduced need for hospitalization and ED visits

10 | Provincial approach to outcomes and deliverables management

Centralize patient information to share and manage care across all health care providers

Core issue in Manitoba

- Limited collection of performance data across the province
- Variation in clinical data collection across regions (e.g., trauma data only captured at HSC, critical and acute care database only in Winnipeg)
- Lack of integration between various patient information platforms resulting in multiple assessments and tests
- Few levers to drive performance oversight and quality improvement at a provincial level

Nature of change

- Shared Health and Manitoba Health will work with relevant parties including providers and academic researchers to collect and analyze data in key priority areas to inform system planning, performance monitoring and quality improvement
- Provincial clinical governance will use provincial data to support healthcare providers in meeting established outcomes and to identify gaps in care for particular geographies or populations and to support standardized practice
 - Provincial transparency enables operational planning in the regions
- Assessment of provincial standards and referral protocols will be enabled through provincial data analysis supports, through Information Management and Analytics (IM&A) and Shared Health Quality and Learning
- Provincial outcomes will need to integrate both quality and cost/funding into an integrated set of performance expectations for all settings and care providers in the integrated provincial system

Measures of success

- Increased use of data in provincial planning exercises (e.g., by provincial governance network)
- Increased compliance with provincial standards and referral protocols
- Provincial prevention programs focused on priority areas as identified by data and clinical outcomes

Reference points

USA & Canada | National Surgical Quality Improvement Program

- Standardized approach and online platform for participating hospitals to capture high-quality clinical data
- Responsible for preventing 250-500 surgical complications and saving 12-26 lives each year

BC | Trauma Registry

- Two Trauma Registry's, Minimum Dataset and Comprehensive Dataset are used to support improvement in quality of care and facilitate system-level performance improvement

BC & ON | Perinatal Databases

- Databases contain obstetrical and neonatal records for all births
- Data is used to support research, service planning and evaluation

Canada | RAI-MDS

- Standardized assessment tool and data source for patients in or requiring long-term care and/or community care
- Ensures a standardized, holistic assessment of care needs

Potential Measures of Success Across 10-Point Plan







1	<ul style="list-style-type: none"> All hubs following standard pathways and clinical practices Reduced variation in practice Improvement and consistency across quality measures Increased service provision in currently under-resourced areas 	2	<ul style="list-style-type: none"> All hubs follow standard pathways and clinical practices Reduced patient transport to Winnipeg Reduced inflow/outflow ratio of where patients receive care (e.g., more patients receiving care in their home region)
3	<ul style="list-style-type: none"> Increased access to home and community care post-discharge Reduced proportion of patients paneled for long-term care Increased use of itinerant teams to provide specialized care to rural/remote communities Reduced average LOS and ALC LOS 	4	<ul style="list-style-type: none"> Increased use of digital tools including telehealth (for clinical use), tele-home care, eReferral and eConsult Reduced patient transport to Winnipeg Increased number of patients with chronic conditions using self-monitoring tools
5	<ul style="list-style-type: none"> Reduced patient transport to Winnipeg Reduced inflow/outflow ratio of where patients receive care (e.g., more patients receiving care in their home region) Decreased wait times for specialist care Increased adoption of inter-disciplinary practice 	6	<ul style="list-style-type: none"> Increased access to prevention and screening programs for targeted populations including increased cancer screening for Indigenous populations Increased patient satisfaction (e.g., proportion of people dying in their preferred location)
7	<ul style="list-style-type: none"> Increased number of professionals working in advanced/enhanced roles (e.g., advanced practice roles) Increased recruitment and retention of providers to lower resourced areas Optimal service provision by provider type Decreased wait times for specialist care 	8	<ul style="list-style-type: none"> Increased use of centralized referral programs Reduced time to specialist consult
9	<ul style="list-style-type: none"> Decreased wait times for specialist care More efficient distribution of HHR across the province to support the shifts in service provision location 	10	<ul style="list-style-type: none"> Increased use of data in provincial planning exercises (e.g., by provincial governance network) Increased compliance with provincial standards and referral protocols Provincial prevention programs focused on priority areas as identified by data and clinical outcomes

Provincial Transformation Levers

Achievement of Manitoba's bold vision requires synchronous planning across multiple transformation levers

Overview

Key transformational levers are identified as provincial enablers to successful implementation of the future model. Manitoba's health system leaders have been working to implement changes within each lever. The future model will build upon and accelerate existing initiatives by taking a provincial approach to priorities and planning. These transformational levers are expected to be sequenced and planned in lock step with the core clinical shifts recommended.

Transformation levers					
Funding and Remuneration	Partnerships for Improved Health	Health Human Resources	Infrastructure	Technology and Equipment	Integrated Clinical Services (Diagnostic Services, EMS/Patient Transport)
<p>A key lever to change will be the alignment of funding models to promote the behaviours, care models, and outcomes desired in the future model</p> 	<p>The future model recognizes that many elements of care delivery, prevention, and population health are most effectively addressed in collaboration – within and outside the health system</p> 	<p>The future model considers the geographic realities of HHR, including known challenges in recruitment/retention. The model helps to build capability across the province; including the important role of UoM in HHR training and development of the health workforce of the future</p> 	<p>The design, capability, and capacity of existing spaces will need to be aligned with clinical service shifts</p> 	<p>The ability of network hubs to deliver tele-care and tele-health is critical to promoting care closer to home; including appropriate local network availability; address other pressures offering safe and secure consultation services</p> 	<p>The accessibility, siting, sizing, and coordination of diagnostics services and EMS/patient transfers will need to be aligned with clinical service shifts</p> 

Funding and Remuneration

Funding and Remuneration

A key lever to effecting change will be the alignment of funding models to promote the behaviours, care models, and outcomes desired in the future service delivery model. Implementation of the CPSP will depend on aligning health system funding with new models of care, settings of care and creating value for desired outcomes.

For example, enhanced home and community care through a provincial model will require shifts in funding to promote early discharge and enhanced home care (including in-person and virtual care).

Funding shifts to promote integrated care include:

- **Shared care and inter-professional team models:** Enhanced primary and community care services with mental health and addictions, chronic disease, palliative care and seniors care being core to local service delivery with consistent and reliable support from provincial resources teams in a shared care model that recognizes the contribution of all care providers
- **Cross-sectoral funding aggregation:** Pooling available funds with organizations beyond the health sector to deliver community-based services (e.g., community-based services, housing, private partnerships)
- **Funding redistribution:** Transfer of current service delivery funds to support care in the most appropriate setting and building capacity to align funding with the service delivery design
- **Aligning funding with targeted outcomes and performance:** Developing funding models and contract deliverables that foster adoption of provincial service standards, shifts in the mode of service delivery, and movement beyond compensation for individual health service transactions to models valuing more longitudinal outcomes linking quality and cost. Innovative funding models such as bundled care and activity-based funding can incentivize more coordinated care and reduce fragmentation across healthcare silos and settings by transferring decision-making and risk to the providers to incent value-based outcomes. Changing funding models requires better understanding of the variation in cost of care across the province (e.g., case costing) to consider new funding model options.

Funding and Remuneration | Medical Remuneration

In addition to sector and organizational funding, medical remuneration will have to be aligned to the CPSP including alignment of funding models to promote the behaviours, care models, and outcomes desired in the future model. Sustained change in the future model involves:

Initiatives	Key considerations
Enhanced Local Shared Care and Inter-professional Models	<ul style="list-style-type: none"> Enhanced primary health services with consistent and reliable support from provincial resources teams in a shared care model will require a remuneration model that recognizes the contribution of all care providers. Increased community-based management of mental health and addictions, chronic disease, palliative care and seniors care will likely result in increased primary care provider remuneration for supporting these populations in the local community. Enhanced focus on prevention and screening through shifting from pay per screen to bundling prevention/screening standards and protocols into standardized deliverables. This could be through a capitation or incentive based model. Reduce reliance on facility-based access to primary care services.
Virtual Assessment, Diagnosis and Treatment Province-Wide	<ul style="list-style-type: none"> Increase in delivery of physician services across hubs remotely requires modernization of remuneration models.
Specialist Coverage and Capacity Building for District and Intermediate Hubs	<ul style="list-style-type: none"> Need to develop new contractual models, including deliverables, for specialists working regular itinerant rotations to align with CPSP roadmap. Travel, accommodation and scheduling will need to be addressed in the development of these models. Provincial teams providing virtual consultation, assessment, diagnosis and treatment will shift specialist services to a hybrid in-person/digital model of care that will impact workload and require modernization of the remuneration arrangements.
Cross-Sectoral Funding Aggregation	<ul style="list-style-type: none"> Collaborative delivery of community based services with organizations beyond the health sector (e.g., community-based services, housing, private partnerships) will require the ability to pool available funds and may have cost implications.

Funding and Remuneration | Medical Remuneration

In addition to sector and organizational funding, medical remuneration will have to be modernized to align with the CPSP including funding models that promote the behaviours, care models and outcomes desired in the future model. Sustained change in the future model involves:

Initiatives	Key considerations
Aligning funding with targeted outcomes and performance	<ul style="list-style-type: none">• Funding and contract deliverables will need to align incentives with outcomes to move beyond the individual health service transaction to link quality and cost.• Targets and priorities should focus on appropriate utilization management (e.g., specialists returning patients to the care of their primary care provider once their course of care with the specialist is complete, pediatricians not doing well baby visits, primary care providers making appropriate specialist referrals).• Select sites will require specialized deliverables management for Indigenous outreach as part of role expectations.
Funding Redistribution	<ul style="list-style-type: none">• Where possible, transfer of current service delivery funds to setting of care and building capacity to align to design.• Ability to redistribute funding is dependent on the alignment of timing of system shifts as outlined in the CPSP roadmap.
Site Re-profiling	<ul style="list-style-type: none">• Re-profiling of sites will require a restructuring and rebalancing of call coverage remuneration and remuneration for physician services based on the hubs.

Partnerships for Improved Health

Partnerships for Improved Health

The future model recognizes that many elements of care delivery, prevention, and population health are most effectively addressed in collaboration – within and outside of the health system.

In addition to enhanced focus on prevention activities, the provincial model will provide the foundation for a more proactive approach to building greater linkages with partners within and outside of health, including leaders in Indigenous health, community housing, social services, and patients/communities themselves.

Sustained change in the future model involves:

- **Improved prevention and health literacy through partnership with public health and community providers:** Reduce disease incidence and injuries through improved health education and literacy delivered by public health (e.g., diabetes education, spinal cord injury prevention). Shared models of care to expand capabilities and capacity of local health providers in collaboration with public health (e.g., well baby visits, immunizations)
- **Extended reach and support through non-health providers:** Clear roles and accountabilities for non-health entities who deliver community and social support services (e.g., homemaking services, community-based fitness and health services, meal preparation and delivery, municipal programs, transportation, food security, housing).
- **Integrated planning with cross provincial services:** Alignment in planning of triage criteria, patient routing, and benchmarks for transport with provincial EMS/patient transfer services (e.g., for trauma services, stroke) and alignment of capacity and flow of diagnostic services to enable clinical care.
- **Cross-sectoral planning for care:** Provincial/federal alignment to enable shared planning for services, equitable access to care, and consistent information flow for Indigenous populations. Collaboration in planning for policy changes that cross ministries and addressing challenges of public housing and socioeconomic status.

Partnerships for Improved Health | Enabling Prevention

Current state challenges

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

- **Medical complexity:**
 - In FY15/16, 50%+ of Manitobans aged 40+ had one or more chronic conditions
 - Manitoba's diabetes prevalence is above the Canadian rate of 7%; Prevalence of diabetes in NRHA is 2x the provincial rate
- **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
 - 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.

Greater risk of equity and access challenges in harder to reach populations with implications for health services utilization

- Variable access to early primary health prevention, screening, and intervention across the province.
- Greater risk of equity challenges among Indigenous population and in northern/remote areas
 - Higher proportion of patients diagnosed with late stage cancer in NRHA than the rest of Manitoba (23.6% vs. 19.5%)
 - 50%+ adults in Opaskwayak Cree Nation diagnosed with depression or anxiety, but have low engagement with mental health services
 - Women in NRHA and SHSS wait significantly longer than the rest of the province from screening by mammogram to final diagnosis
- Potential to reduce avoidable health utilization through greater prevention/health promotion:
 - COPD is the leading cause of ED visits/ hospital admissions
 - Limited supports for people with low-moderate risk of kidney disease
 - 35% increase in rate of gonorrhoea among Manitoba youth since 2012

Fragmentation of planning and information flow impacts on ability to better align to population needs

- Planning for public health and health services are done separately, leading to missed opportunities for integration
- Limitations in integration of public health and population health data and ability to draw insights to inform provincial planning
- Gaps in available core information technology solutions and connectivity to facilitate outreach and virtually delivered care
- Recognition of inconsistent communication processes and inconsistent availability of full clinical documentation tools that link with public health

Identified need for enhanced collaboration to coordinate and advance prevention and population health needs

- Noted areas of duplication across primary care and public health teams (e.g., well baby visits, school health)
- Providers in public health, prevention, and wellness recognized as key team members and drivers in reducing avoidable entry to health services; however there are inconsistent processes and linkages across services
- Areas of focus identified in PCT discussions include for example:
 - Chronic disease management with focus on diabetes
 - Mental health and addictions
 - Indigenous specific health needs and outreach
 - Social determinants of health (e.g., social complexity, affordable, accessible housing)

Partnerships for Improved Health | Enabling Prevention

The future Public Health strategy will need to enable close collaboration with other health providers, particularly at local area hubs. Public Health will play a key role in working together to confirm processes, roles, and responsibilities to better leverage existing resources and investments to address priority challenges in disease/injury prevention and population health.

Increased Population Health Outcomes Monitoring

Initiatives	Key considerations
Information Technology	<ul style="list-style-type: none">• Create connection between Laboratory Information Systems and the Public Health Information System (PHIMS) to minimize duplicate data entry to redeploy public health data entry resource to data quality, routine program monitoring and auditing• Create connection between hospital/ birthing centres, primary care and Women's health providers re: electronic Prenatal record, Post Partum referral, to increase efficiency of referrals and information sharing with public health• Champion the collection of client ethnicity identifiers relevant to care provision in administrative data

Outreach to Targeted Populations

Initiatives	Key considerations
Healthy Social Environment	<ul style="list-style-type: none">• Work in partnership with communities, government, and other stakeholders to enhance social inclusion and access to the determinants of health to reduce inequities including meaningful engagement with Indigenous communities to eliminate stigma and discrimination, anti-racism, reducing poverty• Provide cultural safety professional development for all staff and develop a strategy to support an overall culturally safe organization(s)• Develop a model that will identify structural barriers to why individuals are not accessing care e.g., racism, including identifying opportunities to directly improve access through community engagement and community-based services

Partnerships for Improved Health | Enabling Prevention

Improved Chronic Disease Management

Initiatives	Key considerations
Early Childhood Development	<ul style="list-style-type: none">• Enhance evidence informed and culturally safe programs with families in the prenatal, post-partum and early parenting periods including access to the Families First program• Work in collaboration with service providers, stakeholders, and Indigenous communities to support families and remove barriers to community resources and health services
Health Promotion and Non-Communicable Disease Prevention	<ul style="list-style-type: none">• Identify synergies in initiatives and develop a multi-tiered comprehensive approach to chronic disease prevention that includes 1) health services and clinical interventions targeting individual behavior 2) community-level interventions; and 3) a whole of government approach working across departments• Enhance universal and targeted health promotion communication that is appropriate to all populations e.g., websites, social marketing, and social media.• Work in collaboration with service providers and stakeholders to support people to access the social determinants of health and remove barriers to community resources• Implement evidence based approaches to preventing falls among community living older adults and/or targeted programming for older adults who have experienced a fracture and who present a greater risk to re-fracture

Partnerships for Improved Health | Enabling Prevention

Prevention of Disease and Injury

Initiatives	Key considerations
Communicable Disease and Immunization	<ul style="list-style-type: none">• Collaborate with health providers to develop an improved model of TB prevention and care for all people in Manitoba, with the inclusion of Indigenous and newcomer communities• Work with primary care providers, community stakeholders and Indigenous health experts to achieve target immunization coverage rates through the promotion and utilizing of best providers and considering effective delivery models
Substance Use and Harm Reduction	<ul style="list-style-type: none">• Enhance harm reduction approaches including establishing provincial harm reduction supplies and distribution program• Incorporate culturally safe harm reduction initiatives and strengthen peer supports/networks and scale up existing harm reduction programming• Ensure consistent training of health care professionals on a harm reduction approach to care across regions and cultural safety
Sexually Transmitted and Blood Borne Infections (STBBI)	<ul style="list-style-type: none">• Strengthen STBBI prevention, testing, treatment and management with a priority on prenatal care and prevention of congenital infections (e.g., HIV and syphilis)

Health Human Resources

Health Human Resources

The future model considers the current realities of sustaining health human resources (HHR) while building capability across the province. Sustained change in the future model will involve addressing a number of priority areas:

Priority Areas	Key Considerations
Provincial HHR planning	<ul style="list-style-type: none"> Based on required capabilities, competencies, and service standards across the network model, planning will be undertaken collaboratively with service delivery organizations and will be driven by provincial analysis of available resources. Strategies will match necessary human resources with population health needs and sustainably close the gap between available and required resources throughout the province
Representative Workforce and Cultural Safety	<ul style="list-style-type: none"> Develop and implement workforce policies, strategies and programs to support the delivery of culturally safe care, including, but not limited to, increasing the number of Indigenous health professionals, supporting the retention of Indigenous providers in Indigenous communities, and providing cultural competency training for all health care professionals
Promotion of optimal scopes of practice	<ul style="list-style-type: none"> Opportunities for nursing and professional/technical paramedical staff to take on roles and responsibilities that fully optimize their scope of practice and work in a team model with physicians to extend capabilities (e.g., advance practice physiotherapist screens for conservative vs. surgical treatment instead of the surgeon) Maximized opportunities for assistants, support staff, aides, to take on roles and responsibilities where appropriate in order to free capacity of other professionals (e.g., health care aide is cross trained to support rehabilitation and nursing goals in the home)
Alternate HHR models	<ul style="list-style-type: none"> Support for inter-professional, collaborative models to optimize alignment of available resources with population needs <ul style="list-style-type: none"> Shared care / inter-professional model: extend the My Health Team inter-professional model for members with capabilities to manage low to moderate health and addictions, chronic disease management, wound care, dementia care. Consistently engage allied health, public health and community support services into the My Health Team model to advance healthy aging, health promotion, prevention and screening Itinerant model: extend dedicated itinerant specialist models to support local and district hubs and bring greater specialization of care and clinical education to providers in district and local area hubs
Strategies to grow the workforce	<ul style="list-style-type: none"> Leverage connections with existing initiatives to build interest in health services careers in rural, remote, northern regions by fostering local entry into health professional programs at all levels. This will include working in partnership with stakeholders to grow the workforce in priority areas, including distributed education and training and early exposure pipeline programs.

Health Human Resources

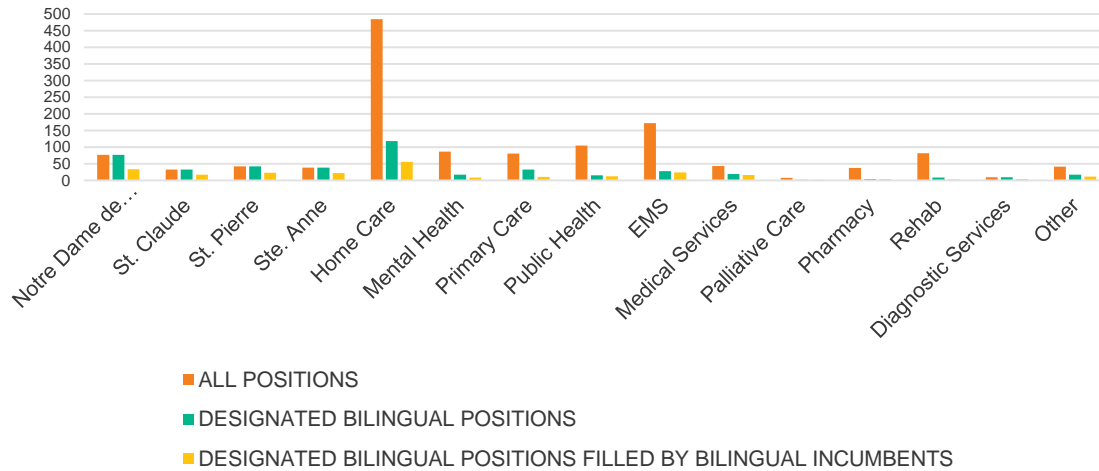
The future model considers the current realities of sustaining health human resources (HHR) while building capability across the province. Sustained change in the future model will involve addressing a number of priority areas:

Priority Areas	Key Considerations
Enhanced knowledge translation	<ul style="list-style-type: none"> • Intermediate, Provincial, and District hubs, to support education and skill-building, in order to better coordinate access to current workforce capabilities <ul style="list-style-type: none"> • (e.g., Winnipeg specialized rehabilitation team to provide ongoing follow-up, assessment and education to local teams as well as directly to the patient in their homes) • Clinical governance to identify existing training curricula adopted by existing regions or organizations that can be scaled up provincially and promote standardized practices that enhance competencies across disciplines
Training for the workforce of the future	<ul style="list-style-type: none"> • Work with colleges and universities, including the University of Manitoba, to identify key areas for shifts in curricula and clinical experiences including, but not limited to: cross-training opportunities in nursing and basic rehabilitation for Health Care Aides; training on applications of virtual and delegated models of care for allied, nursing, and physician providers; greater understanding of unique rural, remote, and Northern clinical elements of care across all professionals • Clinical governance to identify provincial or regional leaders to monitor competencies align with expectations to deliver quality outcomes
Coordinated planning for French Language Services	<ul style="list-style-type: none"> • Aligning the province's health human resource strategy to serve the Francophone population in rural, urban and northern communities is essential to the active offer of services in French • Key enablers for implementing the model for the Francophone population include: <ul style="list-style-type: none"> • Maintaining and enhancing the role of health provider education and liaison with institutions that educate in French and other places of learning where bilingual students study • Enhanced and standardized identification of Francophones along with regular evaluation of the Francophone population health status, needs and gaps in service paired with consistent identification of bilingual health care providers • Utilizing innovative models including digital tools to extend the availability of health services in French • Francophone governance of designated sites/agencies and strong Francophone leadership at all levels to develop and implement a strategic French Language Services plan that creates a fully integrated and standardized approach to service • Working with both the Francophone Affairs Secretariat and Santé en français to support the coordination of planning and delivery of services in French

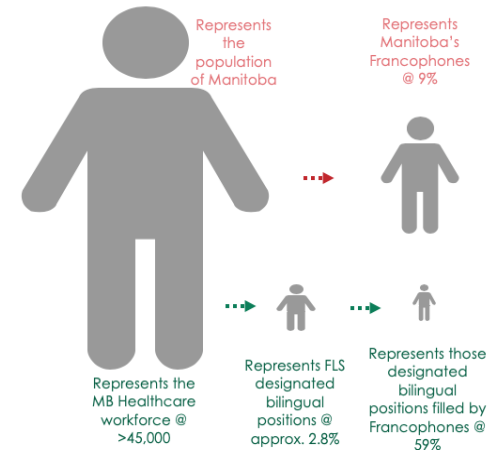
Manitoba's Francophone Health Human Resources

Key Facts

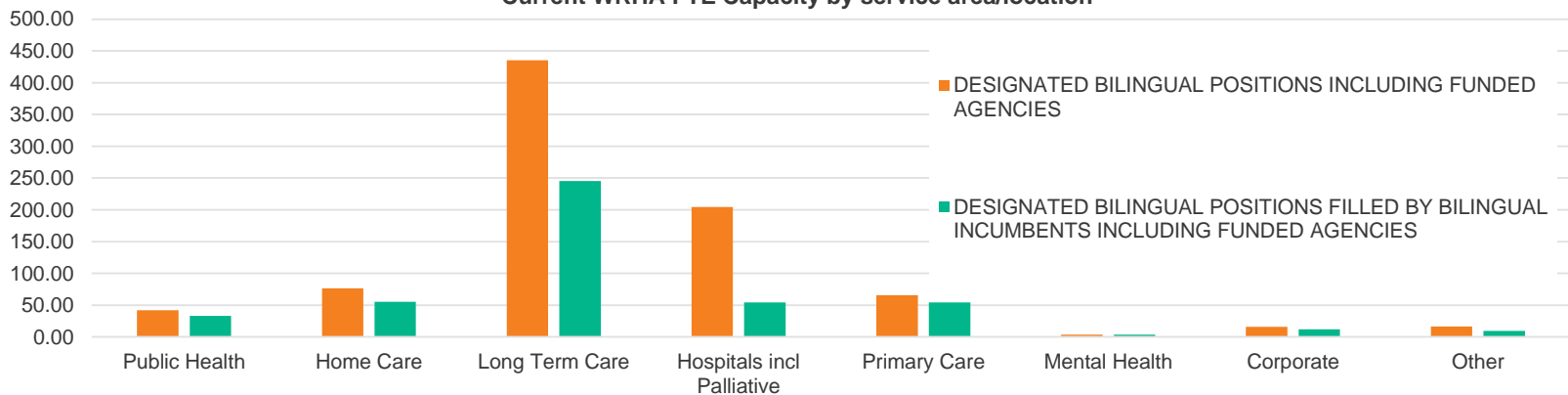
Current Southern Health-Santé Sud FTE Capacity by service area/location



Current Healthcare workforce capacity in terms of Designated FLS positions relative to Manitoba's Francophone population



Current WRHA FTE Capacity by service area/location



Coordinated Planning for French Language Services

- In Canada, linguistic duality is one of the fundamental dimensions of history. As a multicultural society, Canada's two official languages, English and French, have retained their special status as languages used in the public domain. All but one of Manitoba's Regional Health Authorities are designated bilingual. In accordance with the Government of Manitoba's French Language Services Policy and the *Francophone Community Enhancement and Support Act*, these RHAs are legislatively responsible for the provision of bilingual health care services. Health Standards Organization now recognizes linguistic norms as a standard in ensuring patient centred quality care focused on safety and equity.
- A significant number of programs/services, agencies and facilities are designated as bilingual or francophone however the level of actual bilingual services offered and delivered varies across the entities in part due to challenges with recruitment and retention. There is a current misalignment of system capacity to deliver services in French in many areas. Adoption of an approach identifying priority populations and the associated required level of bilingual response is needed as is an acknowledgement of a principle of critical masses of bilingual professionals.
- Aligning the province's health human resource strategy to serve the Francophone population in rural, urban and northern communities is essential to the active offer of services in French. Fundamental to the success of these efforts is an organizational culture that normalizes and values the provision of bilingual services in health care. FLS is supported by Shared Health leadership who will play an active role in creating the necessary ambience, culture and organizational structure. Ongoing evaluation and surveillance of needs and successes will support this necessary shift.
- Based on research and experience, six priority populations are deemed highest need within the francophone population: children, seniors, immigrants/refugees, those with mental health conditions and addictions and those needing maternal, acute and palliative care.

Health Human Resources | Measures of Success

As the future HHR plan is developed, key performance indicators should be aligned with the goals of the Clinical and Preventive Services Plan. Developed by Shared Health, the following measures can be leveraged in implementation planning

Objective	Measures of Success	Indicators
Shift in care among disciplines to optimize scope of practice and extend provider capacities	<ul style="list-style-type: none"> Increased number of professionals working in advanced/enhanced roles (e.g., advanced practice roles) Optimal service provision by provider type 	<ul style="list-style-type: none"> Change in demand by providers for increased competencies (education and training) for advanced practice roles Increase in supply of advanced practice providers ratio of provider types working in advanced roles compared to total provider types working in the system. Measured pre and post CPSP implementation Reduction in lower-acuity clinical services performed by physicians increase in levels of clinical service provided by non-physician advanced practice providers
Shift in distribution of providers to match shift in service provision location given the objective of services being provided closer to home	<ul style="list-style-type: none"> More efficient distribution of HHR across the province to support the shifts in service provision location Increased use of itinerant teams to provide specialized care to rural/remote communities Increase in recruitment and retention of providers in lower resourced areas Increase in service provision in currently under-resourced areas 	<ul style="list-style-type: none"> Decrease in the number of HHR hotspots (number of communities without access to basic primary care services) Increase in types and volume of services provided in currently under-resourced areas Increase in the number of providers with practice located in currently under-resourced locations Change in vacancies for clinical positions in currently under-resourced areas Increase in types and volume of services provided in currently under-resourced areas Increase in access to services by population in previously under-resourced locations Increase in the number of providers with practice located in currently under-resourced locations Increase in the number of itinerant services provided in currently under resourced areas
Increased adoption of new models of care	<ul style="list-style-type: none"> Increased adoption of inter-disciplinary practice 	<ul style="list-style-type: none"> Increase in the number of multi-provider practice type (team based care provision) in the community Increase in the number of non-physician providers (PA/CAs) integrated into hospital based practice
Increased adoption of digital health enablers	<ul style="list-style-type: none"> Increase in use of digital tools including telehealth (for clinical use), tele-home care, eReferral and eConsult 	<ul style="list-style-type: none"> Increase in the ratio of virtual care services to in-person services Increase in the number of providers with EMRs Increase in the number of providers engaged in the delivery of clinical services through digital health enablers (e.g., telehealth)

Infrastructure

Infrastructure

The design, capability, and capacity of existing spaces and equipment will need to be aligned with clinical service shifts. Specifically current capacity of existing facilities requires reassessment to align with estimated shifts in volume and type of care at the provincial and intermediate hubs. Future role definition of sites requires evaluation of impacts on other support services.

Current state challenges

- Current capacity of existing facilities requires reassessment to align with estimated shifts in volume and type of care at the provincial and intermediate hubs. Future role definition of sites requires evaluation of impacts on other support services (e.g., regional laundry, medical device reprocessing).
- Patient-centred design of facilities will become important as local and district hubs bring multiple types of providers together virtually and physically

Priority Areas

Key Considerations

Align infrastructure to clinical footprint

- Early role realignment will focus on shifting care closer to home by re-profiling low-volume District Hubs to Local Area Hubs delivering enhanced primary and community care
- A provincial assessment of existing infrastructure is a foundational first step that needs to be completed to inform clinical realignment. Assessment and future role redefinition of hubs also requires evaluation of impact to support services (e.g., regional laundry, medical device reprocessing) as these will also need to be aligned
- Future capital investments should be aligned to capability building at the local and district level.

Shore up initial set of District Hubs

- In the new model, District Hubs will strengthen their acute care and procedure capabilities with a sub-set delivering 24/7 emergency services, day surgery and low-risk births
- These facilities will likely experience an increase in volumes as a result of the reduction in the number of District Hubs and the increase in support from the Intermediate Hub
- Future capital investments should focus on ensuring these facilities have the space and equipment, including virtual care and connectivity to Intermediate and Provincial Hubs, that is required for their new clinical profile
- Investments in medical device services will need to align with surgical sites within the District Hubs

Infrastructure

The Network Model creates a provincial framework for infrastructure investments

Priority Areas	Key Considerations
Enhance capacity in Brandon and Northern Hub	<ul style="list-style-type: none">• Intermediate Hubs in Brandon and enhanced care capability in the Northern Hub will need to accommodate increased volumes (e.g., surgery, acute medicine, critical care, NICU) and increased clinical capabilities (e.g., surgery, ICU, rapid referral clinic for acute medicine)• Medical device services will need to align with the new capabilities of intermediate hubs• New patient transport model will include managing transport for scheduled care and transport receiving facilities will have space considerations• In addition to on-site clinical care, Intermediate Hubs will provide virtual and consultative support to surrounding District and Local Area Hubs which may require dedicated space and equipment• Enhancement of Northern Hub will need to consider factors beyond the health system (e.g., housing capacity for staff, private transportation systems and patterns) and cost premiums associated with the development of infrastructure in the North
Repurpose capacity in Winnipeg	<ul style="list-style-type: none">• As a result of enhanced activity in Brandon and Northern Hub, surgical, acute medicine, critical care and NICU volumes will shift out of Winnipeg and specialists will be more active in providing virtual support, which will require dedicated space appropriate to this new function• New patient transport model will include managing transport for scheduled care and transport receiving facilities will have space considerations

Technology and Equipment

Technology and Equipment | Enabling Digital Health

Current state challenges

Fragmentation of planning and procurement impacts on interoperability and benefits realization

- Lack of clarity in linkage across clinical and information governance
- Fragmentation of request and prioritization processes provincially
- Planning for digital health strategies is done separately across jurisdictions and clinical programs
- High number of solutions and vendors creates challenges to manage and gain efficiencies
- Multiple siloed systems reflect local innovations; however, these have led to duplicative functions, limited interoperability and efficiency, and lack of enterprise or coordinated eco-system structure, and limited access to a patient centric record of care

Variable consistency and quality of clinical and financial data impacts on access to advanced insights

- Limited transparency and visibility of patient information to the patient and across organizational and jurisdictional boundaries (e.g., federal and private diagnostic imaging repositories are separate from provincial)
- Variability in quality of information shared (e.g., discharge summaries not consistently available to primary care providers)
- Limited data in place to support patient pathway tracking across the province
- Limited options for tracking and resource planning provincially
- Available analytics initiatives are primarily targeted, rather than enterprise- focused
- Gaps in clinical and business data systems limit available data and opportunities for operational and predictive risk analytics to optimize flow, resources, and insights (e.g., gaps in triage and patient flow, gaps in mental health and addictions)

Gaps in available core information technology solutions and connectivity

- Inconsistent availability of full clinical documentation tools (e.g., pharmacy systems not in place in all hospitals)
- Certain communities continue to face gaps in basic connectivity and infrastructure to support remote monitoring/virtual care
- Certain areas of the health continuum are less consistently connected and/or have lower uptake of digital tools (e.g., mental health and addictions, home care)
- Currently there is no provincial solution for e-referrals, centralized intake/scheduling, or e-consultations

Variable access to secure digital solutions to transform equity of access and patient experience

- Inconsistent availability of digitally enabled modes of care which could extend the reach of limited health human resources (e.g., to match patient demand, reduce avoidable patient travel, particularly in rural and remote/Northern communities)
- Active tele-health network has greater uptake among certain services (e.g., cancer) than others (e.g., rehab)
- Challenges in change management impacts on usability of available technology
- Limited secure options for communication with concerns over unsecure methods being used as workarounds as part of informal networks for consultations
- Need to balance cyber-security and privacy legislation within and across jurisdictions while optimizing usability and timeliness of information flow

Technology and Equipment | Enabling Digital Health

Alignment of Digital Health planning with Manitoba's CPSP will be critical in supporting shifts of providers roles, service standards, and patient experiences. The future Digital Health strategy will need to enable providers to work together, communicate securely, and better leverage existing investments to address current challenges in patient travel, inefficient processes, and variable uptake of available digital tools, among others.

In order to achieve the future CPSP, three priority areas in digital health have emerged to enable a common platform for patients and providers including:

Priority Areas	Key considerations
<p>Common patient information and provincial outcomes data</p> <p>Support and accelerate initiatives to create a common provincial information platform and dataset</p>	<ul style="list-style-type: none"> • Reduction of fragmentation in digital tools and interfaces supports potential future reduction of avoidable duplication of data and set foundation for future analytic capabilities • Creating common information platforms creates greater opportunities for advanced analytics to inform system planning, resource management, performance monitoring, and quality improvement • Tools should interface with existing provincial databases while maintaining consistency and privacy of patient information to support the flow of information and patients across current organizational and regional boundaries (e.g., through data warehouses, data pools, health information exchanges) • Shared Health would support and oversee establishment and management of provincial standards and processes as well as solutions • Need for privacy and jurisdictional issues to be proactively addressed (e.g., information sharing frameworks, federal rules regarding use of systems/access, infrastructure gaps)
<p>Tele-care (e.g., tele-homecare)</p> <p>Standardize available tools to support remotely delivered patient care and self-management</p>	<ul style="list-style-type: none"> • Tele-care tools are a key component in improving patient satisfaction, enabling shifts of care closer to home, promoting early identification and intervention of health needs, and reducing avoidable ED visits and hospitalizations • Home or community based programs can offer more intensive virtual health counselling, provincial coordination, remote monitoring of biometrics and client reported health to support self-management at home (e.g., for patients living with chronic and complex medical needs such as COPD, Diabetes, CHF and mental health illnesses) • Tele-care functions will need to be supported by provincially standardized clinical and business processes for client referral, intake, delivery, and discharge and strategies to realign current patient service delivery models to virtual care

Technology and Equipment | Enabling Digital Health

Priority Areas	Key considerations
Tele-health/virtual Care Consolidate and scale a provincially coordinated platform for tele-health solutions triaging to allow providers to learn and communicate in a more streamlined, accessible, and consistent manner and promote care closer to home and optimize a more connected patient experience	<ul style="list-style-type: none">• Current fragmented tele-health tools (e.g., eConsult, secure messaging and simulation tools, eReferral, digitized navigation) would require consolidation to promote consistency of information, alignment of processes, and build flexibility for future upgrades.• Functions will need to be supported by provincially standardized clinical and business processes for client referral, intake, delivery, and discharge and strategies to realign current service delivery models to virtual care• Tech solutions require parallel streamlined and consistent referral pathways and protocols to support effective uptake of tele-health and promote care closer to home• Applications of tele-health would include shifts between members of the interprofessional team (e.g., shifts of care from specialists to primary care), support for timely advice and consultation (e.g., orthopaedics, mental health and addictions, diagnostic services, specialized allied health and nursing professionals)• Consider opportunities for integration of consumer health elements for patient enablement through a mix of phone and internet-based solutions to support access (e.g., patient self-navigation, electronic appointment booking and reminders, secure communication between patients/providers)• Shared Health would support and oversee establishment and management of provincial standards and processes as well as the consolidation of solutions

Integrated Clinical Services

Integrated Clinical Services

The accessibility, siting, sizing, and coordination of integrated support services will need to be aligned with clinical service shifts.

This includes:

- **Aligning Diagnostic Services:** Diagnostic Services, Shared Health will continue to play a key role in aligning current and needed capacity at each level of the provincial model and ensuring consistency in service and funding for equitable and timely access. Alignment of services with the network model will ensure timely care and testing across hubs
- **A Coordinated Transport Model:** a new model needs to incorporate transparency of services through EMS providers and coordinated inter-facility transfers including scheduled and multi-patient transportation
- **Provincial Coordinated Access:** in alignment to the commitment to collaborative model for supporting Indigenous Health capacity-building, further planning is needed to enable greater information sharing across federal and provincial jurisdictions

Integrated Clinical Services | Aligning Diagnostic Services

Current diagnostic services face challenges balancing availability and timeliness expectations with capacity and utilization

Current State

Variable clinical practice driving diagnostic expectations

- Utilization of diagnostic services in rural and remote areas varies by practice setting (itinerant vs. community-based) and historic service availability patterns

Low utilization of diagnostic resources in rural and remote areas

- Variation in utilization of diagnostics depending on volumes. For example, some x-ray machines are only being used once per day

Priority Areas	Key considerations	Timeline
Provincial Diagnostic Standards	<ul style="list-style-type: none"> The current diagnostic capacity of existing facilities requires reassessment to align with expected shifts in volume and type of care at the provincial and intermediate hubs. For example, Intermediate Hubs in Brandon and in Northern Manitoba are expected to see increases in surgical (e.g., joint replacement, general surgery), acute medicine, critical care and NICU volumes This will require standards outlining minimum expectations for availability and timeliness of diagnostic services across the network model. Key considerations for these standards should include service level (e.g., 24/7 EDs at enhanced District Hubs) and community size See the <i>Conceptual Model for Diagnostic Services</i> below for an initial draft of diagnostic services across the network model. This alignment model was developed by Diagnostic Services, Shared Health and can be leveraged in implementation planning 	1-2 years
Centralized Diagnostic Services for patients travelling to Winnipeg Sites	<ul style="list-style-type: none"> PCT discussions highlighted the challenges for patients who travel to Winnipeg from Northern Manitoba and other remote parts of the province for diagnostic services, particularly imaging A lack of alignment between imaging and follow-up appointments often results in multiple trips or transfers The Shared Health site at St. Boniface Hospital has proposed providing a coordination and navigation service that will assist in arranging diagnostic services appointments for patients in an effort to reduce unnecessary travel 	1-2 years

Integrated Clinical Services | Aligning Diagnostic Services

Current diagnostic services face challenges balancing availability and timeliness expectations with capacity and utilization

Priority Areas	Key considerations	Timeline
Formalization and expansion of point of care testing (POCT)	<ul style="list-style-type: none"> Existing pilot initiatives in Swan River and Misericordia Health Centre have demonstrated success in the implementation of POCT in both rural and urban settings There are multiple POCT standards through both Shared Health and Accreditation Canada. Alignment is needed between existing POCT accreditation requirements and organizational structures, mandates and roles PCT discussions have highlighted the key areas where POCT could improve care delivery closer to home (e.g., amnisure and ferning/amnicator for obstetrics; diabetes and CHF testing) Shared Health should also assess opportunities for POCT outside of the laboratory setting including ultrasound and cardiac 	3-5 years
Optimize balance of diagnostic availability and patient transfers	<ul style="list-style-type: none"> In 2017/18, 24% of all inter-facility transfer trips were related to specialized testing (e.g., CT Scan, ultrasound, angiogram, echocardiogram) Implementation of a scheduled transport program will impact where and how diagnostic services should be focused and where additional capacity may be needed 	3-5 years
Provincial coordination of Laboratory Services and Specimen transport	<ul style="list-style-type: none"> To provide an optimized lab system that supports appropriate patient care closer to home in the most sustainable manner, an effective provincial lab specimen transportation system is required. Requirements for transporting lab samples are well defined, and would require a stable seven days per week delivery network that could form the backbone of a provincial transportation system to support other areas of the system such as pharmacy, laundry, mail, supplies, etc. 	5+ years

Integrated Clinical Services | Aligning Diagnostic Services

Current diagnostic services face challenges balancing availability and timeliness expectations with capacity and utilization

Priority Areas	Key considerations	Timeline
Expanding Scopes of Practice	<ul style="list-style-type: none"> In the future model, interdisciplinary teams will play a critical role in the delivery of enhanced community and primary care Providers working in these teams (e.g., NPs, midwives, RNs) will be working to full scope of practice including the ability to order lab tests and imaging as appropriate RNs currently have the ability to order lab tests and imaging within approved practice settings however infrastructure (e.g., provider registry) is needed to enable this practice. 	5+ years
Diagnostic Services Workforce	<ul style="list-style-type: none"> In a number of critical discipline areas, there is a major deficit in the availability of qualified and competent diagnostics human resources to support the CPSP for expanded services in the Intermediate sites and expansion of services in District sites. Of particular note, insufficient sonographers, both general and echo, are trained annually in Manitoba to fill existing requirements. Plans for expanding services will put additional strain on this workforce. Plans must be made in partnership with Education to increase the availability of key diagnostics professionals. Stability of staffing in the north has historically been very poor (e.g., laboratory technologists, sonographers). New strategies for staffing models (e.g., itinerant placements, incentives, targeted training programs) must be considered to support the expected clinical service levels. 	5+ years

Integrated Clinical Services | Aligning Diagnostic Services

Developed by Diagnostic Services, Shared Health, this conceptual model for diagnostic services in the network model can be leveraged in implementation planning

	Local <i>Low acuity community-based care</i>		District <i>Low to moderate acuity community-based and inpatient care</i>		Intermediate <i>Moderate to high acuity inpatient and medical/surgical care</i>	Provincial <i>High acuity/specialty medical and surgical care</i>
	<ul style="list-style-type: none"> Local primary care providers, focus on prevention and screening 	Enhanced: <ul style="list-style-type: none"> Interdisciplinary primary care teams who provide enhanced community services 	<ul style="list-style-type: none"> Urgent Care during set hours for low-risk patients Elective Surgery 	Enhanced: <ul style="list-style-type: none"> 24/7 Emergency Dept. Elective and emergency surgery 	<ul style="list-style-type: none"> 24/7 Emergency Dept. Critical Care ICU Elective and emergency surgery 	<ul style="list-style-type: none"> 24/7 Emergency Dept. Critical Care ICU with specialized capabilities Elective and emergency surgery
X-Ray	N/A unless site location or volumes warrant.	N/A unless site location or volumes warrant.	X-Ray	X-Ray	X-Ray	X-Ray
Biochemistry	PCPs collect lab samples and transport to referral lab for testing.	PCPs collect lab samples and transport to referral lab for testing, and potentially limited test menu with point of care testing. If volumes warrant consider dx staff for service delivery.	Limited point of care test menu on-site, transport balance to referral lab for testing. If site location or volumes warrant consider automated lab testing equipment on-site.	On-site lab services for basic test menu.	On-site lab services for basic test menu.	On-site lab services for expanded test menu. Provincial lab hub for specialized testing such as toxicology and metabolic.
Hematology	PCPs collect lab samples and transport to referral lab for testing.	PCPs collect lab samples and transport to referral lab for testing, and potentially limited test menu with point of care testing. If volumes warrant consider dx staff for service delivery.	Limited point of care test menu on-site, transport balance to referral lab for testing. If site location or volumes warrant consider automated lab testing equipment on-site.	On-site lab services for basic test menu.	On-site lab services for basic test menu.	On-site lab services for expanded test menu. Provincial lab hub for specialized testing such as bone marrows.
EKG	N/A (unless only access to EKG in community)	N/A unless site location or volumes warrant.	EKG	EKG	EKG	Required for cardiac centre (St B) also HSC
Stress	N/A	N/A	Stress (dependent upon access to supervise testing)	Stress (dependent upon access to supervise testing)	Stress	Required for cardiac centre (St B) also HSC
Holter	N/A	N/A	Holter (dependent upon volume and distance to next centre)	Holter	Holter	Required for cardiac centre (St B) also HSC
Echo	N/A	N/A	Itinerant clinics	Regional echo hubs TBD based on volumes and site location.	Required (fixed or itinerant) service for intermediate hubs.	Required for cardiac centre (St B) including Stress Echo at SBH also HSC
Ultrasound	N/A	N/A	N/A unless site location or volumes warrant.	Ultrasound	Ultrasound	Ultrasound
CT	N/A	N/A	N/A unless site location or volumes warrant.	CT	CT	CT
MRI	N/A	N/A	N/A	N/A	Regional MRI hubs based on clinical programs, site location and volumes.	Regional MRI hubs based on clinical programs, site location and volumes.

Integrated Clinical Services | Aligning Diagnostic Services

Developed by Diagnostic Services, Shared Health, this conceptual model for diagnostic services in the network model can be leveraged in implementation planning

	Local <i>Low acuity community-based care</i>		District <i>Low to moderate acuity community-based and inpatient care</i>		Intermediate <i>Moderate to high acuity inpatient and medical/surgical care</i>	Provincial <i>High acuity/specialty medical and surgical care</i>
	<ul style="list-style-type: none"> Local primary care providers, focus on prevention and screening 	Enhanced: <ul style="list-style-type: none"> Interdisciplinary primary care teams who provide enhanced community services 	<ul style="list-style-type: none"> Urgent Care during set hours for low-risk patients Elective Surgery 	Enhanced: <ul style="list-style-type: none"> 24/7 Emergency Dept. Elective and emergency surgery 	<ul style="list-style-type: none"> 24/7 Emergency Dept. Critical Care ICU Elective and emergency surgery 	<ul style="list-style-type: none"> 24/7 Emergency Dept. Critical Care ICU with specialized capabilities Elective and emergency surgery
Mammography	N/A	N/A	N/A unless site location or volumes warrant.	N/A unless site location or volumes warrant.	Regional mammo hubs based on clinical programs, site location and volumes.	Regional mammo hubs based on clinical programs, site location and volumes.
Nuclear Medicine	N/A	N/A	N/A	N/A	Regional NM hubs based on clinical programs, site location and volumes.	Regional NM hubs based on clinical programs, site location and volumes.
PET	N/A	N/A	N/A	N/A	N/A	Provincial PET (HSC)
Immunology	PCPs collect lab samples and transport to referral lab for testing.	PCPs collect lab samples and transport to referral lab for testing.	Lab samples transported to referral lab for testing.	Lab samples transported to referral lab for testing.	Lab samples transported to referral lab for testing.	Provincial Immunology / Transplant Immunology Labs
Transfusion Medicine	N/A	N/A	N/A	On-site blood bank	On-site blood bank. Regional hubs / CBS perform cross-match.	On-site blood bank. Regional hubs / CBS perform cross-match.
Microbiology	PCPs collect lab samples and transport to referral lab for testing.	PCPs collect lab samples and transport to referral lab for testing.	Lab samples transported to referral lab for testing. Limited menu POCT kits available.	Lab samples transported to referral lab for testing. Limited menu POCT kits available.	Lab samples transported to referral lab for testing. Limited menu POCT kits available.	Regional hubs perform microbiology testing.
Pathology (includes anatomic pathology and cytology)	PCPs collect lab samples and transport to referral lab for testing.	PCPs collect lab samples and transport to referral lab for testing.	Lab samples transported to referral lab for testing.	Lab samples transported to referral lab for testing.	Lab samples transported to referral lab for testing. Consider limited on-site services to support surgery program.	Regional hubs perform pathology testing.
Autopsy (including Medical Examiner Services)	N/A	N/A	N/A	N/A	Regional hubs provide autopsy service including ME Services	Regional hubs provide autopsy service including ME Services
Genomics	PCPs collect lab samples and transport to referral lab for testing.	PCPs collect lab samples and transport to referral lab for testing.	Lab samples transported to referral lab for testing.	Lab samples transported to referral lab for testing.	Lab samples transported to referral lab for testing.	Provincial Genomics Lab

Integrated Clinical Services | EMS and Patient Transport

Shared Health Emergency Response Services (ERS), which includes Emergency Medical Services (EMS) and Patient Transport, does not have the capacity and resources to address equity deficits in service access and the quality and timeliness of care delivered. For example, in rural Manitoba 60% of EMS capacity is used to provide Inter-facility patient transportation (IFT), of which less than 25% of trips require emergency resources. This leads to delayed response to EMS primary calls and emergent IFT requests and limits the ability of ERS to further develop and provide programs and services to support the health system.

Current state challenges

Emergency Medical Services (EMS) and Paramedicine Care

- System Capacity: Patients experience inconsistent access to care; limited ability to appropriately match competencies to patient needs
- Staffing Capacity: High reliance of casual workforce; continual migration of workforce to larger population centres
- Clinical Competency Maintenance: Lack of clinical education development, infrastructure and inclusion of funding in operational model
- Support Infrastructure: Inconsistent access to clinical information for evaluation, planning and service design

Inter-Facility Transfer (IFT) and Patient Transport

- Resource Optimization: Rural IFT is utilizing the EMS service delivery model; inefficient coordination of EMS & IFT resources
- Lack of Care Coordination results in long waits, provider fatigue, patient and facility complaints
- Transfer of Care Delays due to lack of effective care and transport coordination
- Lack of Specialty Resource capacity causes delays and extended waits for complex transports
- Delayed EMS Response due to utilization of EMS resources for non-emergent IFT patient transport volume

Emergency Consultation and Transfer Coordination

- Disruption to ED Physicians and Referring Physicians and Providers due to the lack of access to medical transfer coordination
- Inappropriate use of ED Resources in Winnipeg as many rural transfers enter Winnipeg system as emergency patients
- Lengthy wait for Specialist Consults, Diagnostic Testing and Specialty Treatment
- Rural Recruitment and Retention is negatively impacted by lack of access to specialty medical consultation resources
- Lack of coordination and management of continuity of care for IFT patients

Three priority areas have been identified to address these challenges:

Priority Areas

Transforming the Service Delivery and Capacity of EMS

Developing a Robust Inter-Facility Transfer and Patient Transport Model

Developing a Provincial Approach To Advice Service Coordination Model

Transforming the Service Delivery and Capacity of the EMS Model of Care

The Manitoba health system is uniquely challenged by geography and population distribution. Winnipeg (WFPS), Brandon (BFES) and Thompson (TFES) account for more than 50% of provincial primary call volume. This service is provided by municipal fire-paramedic programs. In rural Manitoba, 60% of Shared Health Emergency Medical Services (EMS) capacity is used to provide Inter-facility transportation (IFT), of which less than 25% of trips require emergency resources.

Outside the large urban EMS systems, many rural and remote areas experience a lack of EMS staffing resources and rely on on-call staffing models that can further delay emergency response.

EMS in some areas of the province are often provided by paramedics who may not have the same foundational knowledge and opportunities to maintain competencies as those working in higher volume environments with easier access to academic programs, continuing clinical education and clinical support and supervision. Geographic challenges often place paramedics in situations where they are managing critical patients for long periods of time during extended transport to health care facilities.

Current state challenges

System Capacity

Patients experience inconsistent access to care (provider may be an EMR, PCP, ICP or ACP crew) depending on area of the province; lack of electronic clinical data outside Winnipeg limits ability to match competencies to patient needs

Inconsistent access to high-acuity pre-hospital advanced care;

Limited low-acuity community based paramedicine care

Delayed 911 Response due to high volume of Inter-Facility Transports

Inconsistent use of community based medical first response (MFR) providers

Staffing Capacity

- 33% of Shared Health paramedics live in Winnipeg or Brandon
- 80% do not live in the community they work in

High reliance on a casual workforce to fill baseline and surge needs, leading to unpredictable and unstable service delivery and increased response times

Employees migrate to positions in larger populated areas as they gain experience

Some geographical areas experience much higher than average turnover resulting in the additional overhead and repetitive orientation of new paramedics

Clinical Competency

Lack of continuing education or ongoing competency maintenance

Employer-based ongoing clinical education is not prioritized financially and there are insufficient resources to service the large geographical area

Clinical education and supporting infrastructure are not built into the funding model of EMS

Lack of ongoing education to support competency in high risk/low volume situations adds stress to providers and increases risk to patient safety

Support Infrastructure

Inconsistent access to comprehensive clinical information to measure, monitor and evaluate the quality of EMS service delivery, patient care, and provider competencies

Lack of evidence-informed planning and service design leading to reactive versus proactive management

Lack of appropriate supervisory and management structures to meet clinical and operational needs within the geographic realities

Lack of leadership development, coaching and peer support programs

Transforming the Service Delivery and Capacity of the EMS Model of Care

A transformed provincial EMS Model of Care would ensure patients have greater access to proficient pre-hospital care and effective paramedicine programs utilizing the full scope of practice of paramedics. Six initiatives are prioritized to be initiated over the next three years:

Initiative	Key Considerations	Timeline
<p>1. Leveraging the existing WFPS system, implement ePCR (electronic patient care record) province-wide to enable:</p> <ul style="list-style-type: none"> Enhanced patient care delivery via embedded protocols, standards and procedures and integrated clinical monitoring Supporting the provider in identification of quality improvement areas to focus clinical support and clinical competency (training) Operational decision making based on system metrics and targets 	<ul style="list-style-type: none"> Clinical practice enhancement Clinical and operational decision making, program support and planning Provider competencies can be measured and monitored Patient Safety and security of patient information 	Year 1
<p>2. Implement an IFT model to address non-emergent inter-facility patient transportation via scheduled routes between district, intermediate and provincial HUBS utilizing multi-patient, multi-purpose vehicles and IFT receiving areas</p>	<ul style="list-style-type: none"> See Appendix 3B for details 	Year 1
<p>3. Implement a provincial EMS Staffing Model that expands on the opportunities for enhanced clinical competency and eliminates on-call where appropriate</p> <ul style="list-style-type: none"> Leadership staffing to provide multiple levels of support and supervision 24/7 and eliminate on-call where appropriate 	<ul style="list-style-type: none"> Sustainable scheduling Ensures the appropriate clinical skills complement in each ambulance and/or geographic area 	Year 2
<p>4. Implement a provincial standardized Clinical Support model with multiple level of supervision, support and oversight that more closely resemble municipal EMS services</p>	<ul style="list-style-type: none"> Provides access to 24/7 clinical support without utilizing on-call managers Ensures the support and mentorship to junior (less experienced) staff 	Year 2
<p>5. Establish a provincial EMS Education and Competency Maintenance Program with greater access to training resources and location of delivery</p>	<ul style="list-style-type: none"> Standardized curriculum Addresses multiple learning styles Opportunities for field competency 	Year 2-3
<p>6. Extend availability of Paramedicine Services to meet the needs of the health system. Some possible areas of practice include:</p> <ul style="list-style-type: none"> Chronic disease management and support for healthy aging in community Assist with urgent treatments with PCH patients with virtual support Administer Specialty/targeting testing and treatments with virtual support 	<ul style="list-style-type: none"> Increasing access to care Increased equity of services Increased collaboration with other health providers and services 	Year 3

Developing a Robust Inter-Facility Transfer and Patient Transport Model

Local access to acute and specialty care is limited throughout much of the province, resulting in 50,000+ patients being transferred annually between health care facilities, including within Winnipeg, to receive the care they require. Rural patient ground transport services are delivered using the EMS transport model regardless of the level of transport care required (25% emergency and complex vs. 75% stable and non-complex transports). The current combined EMS and Patient Transport model cannot effectively address volume and capacity challenges in the manner that a coordinated transfer and scheduled transport model could. This can result in delayed response to EMS primary calls and emergent IFT requests.

Current state challenges

Resource Optimization	Care Coordination	Transfer of Care Delays	Lack of Specialty Resources	Delayed EMS Response
Inefficient coordination of EMS and IFT resources, including long transfer of care delays (and empty unit traffic) due to lack of consult and diagnostic scheduling and alignment with transport availability	Inter-Facility Transport coordination does not effectively address care coordination resulting in long waits, paramedic/medical escort fatigue, patient and facility complaints	Long offload delays as stable patients are triaged and seen in Emergency Departments before most diagnostics are ordered and/or scheduled	Demand for Medical escorts (including specialized teams) in-province and out-of-province exceeds existing capacity; lack of capacity with escorts/teams for complex transports causing delays as sending site may not have an appropriate medical escort resource/team available	Rural ground IFT is provided using the same model and resources as EMS transport (one ambulance, two paramedics), including for stable, non-complex transfers
Non-emergent transport calls are “parked” for extended durations when there is high EMS or IFT call volume	Frequent delays in facilities for patient consults and diagnostics; missed appointments are contributing to facility bed management issues.	Direct admissions to units can still incur long transfer of care times	Resources: IFTs requiring specialty teams and equipment frequently incur extended waits (bariatric, neo-natal, etc.)	The volume and longer duration of IFT trips are having a negative impact on the rural EMS service to meet primary call response targets and staffing budgets (fatigue replacement, on-call, overtime, etc.)
		Transports for consultation often lead to multiple (unplanned) diagnostics resulting in long wait times for patients in the facility		

An Inter-Facility Transfer and Patient Transport program would ensure effective coordination and continuum of medical care between facilities while meeting the needs of the patient during transport and in-facility waiting periods. Such a program would formalize the following:

- **IFT Care Management:** Ensures all care at the receiving site is planned and services are scheduled to minimize patient wait, avoid contributing to patient flow issues, and optimize repatriation to the sending facility
- **IFT Patient Management:** Ensures fast loading/unloading of patients to a purpose-built receiving area staffed by patient transport personnel to ensure patients are comfortable, personal needs can be met and care components (consults, diagnostic testing, specialty treatments) are effectively managed
- **IFT Transport Management:** Ensures Patients and Medical Escort(s) are transported between hospitals in the most effective and efficient manner as per the level of care required and the transport priority required, utilizing scheduled transport routes and multi-patient vehicles wherever possible to ensure EMS personnel, equipment and ambulances are available for primary call scene response
- **IFT Program Management:** Ensures optimized access to all component services and provides oversight to ensure IFT program is utilized as intended

Developing a Robust Inter-Facility Transfer and Patient Transport Model

A provincial Inter-Facility Transfer and Patient Transport Model would enable consultation and coordination of the safe transfer of patients efficiently and effectively while utilizing the most appropriate mode, method and priority of transport resources, including medical escorts. The IFT Model would reduce transport costs (conversion of stable single-patient 'on demand' transports to scheduled, multi-patient transports where feasible) and decrease trip length, enabling rural EMS to effectively meet emergency call response targets. Five initiatives are prioritized for initiation over the next three years:

Initiative	Key Considerations	Timeline
<p>1. Establish a provincial approach to advice and service coordination to provide a single point of contact for all providers in Manitoba through centralized access to consult on and coordinate the care of IFT Patients</p> <ul style="list-style-type: none"> 24/7 Emergency Physician Specialists to develop IFT Care Plan to ensure patient will receive scheduled care upon arrival, and manage access to care 	<ul style="list-style-type: none"> Digital enablers to support virtual consultations Information Management system to record all contacts and generate IFT care plans 	Year 1
<p>2. Establish an IFT Coordination Service</p> <ul style="list-style-type: none"> IFT specialist coordinators to triage transfers requiring physician consultation to physician/service Requests and/or coordinates patient transport Pre-registers and schedules patient 	<ul style="list-style-type: none"> Pre-registration of patient to receiving facility; processes requests (physician orders) for scheduled diagnostics Coordinates the non-medical aspects of repatriation transport 	Year 1
<p>3. Establish purpose-built IFT Patient Receiving Areas in high-volume transfer facilities to ensure timely transfer of care to release paramedics/medical escorts</p> <ul style="list-style-type: none"> Staffing complement using Patient Transport resources, including appropriately trained paramedics, nurses, respiratory therapists and support staff to allow for a wide range of IFT patient acuity. 	<ul style="list-style-type: none"> Replaces IFT patients being held and/or assessed in ED for access to services Eliminates "hallway" waits for beds, diagnostic services, consults, etc. 	Year 1-2
<p>4. Shift transport platform from EMS transport model (one patient, two paramedics, one ambulance) to a scheduled, multi-patient transport model for stable, non-complex patients (75% of IFT volume), where feasible</p> <ul style="list-style-type: none"> Utilize Multi-patient, multi-purpose vehicles Establish scheduled routes between District, Intermediate and Provincial HUBS 	<ul style="list-style-type: none"> Sustainable transport platform could extend utility (scheduled transport of non-IFT patients for specialist referrals, transport of specialty medical supplies and equipment to local facilities from HUBS) 	Year 2-3
<p>5. Establish IFT Program Governance as Inter-Facility Transfers have many stakeholders that jointly oversee the care of patients and/or are directly impacted by IFT volumes and transfer coordination: Referring Physicians, ED Physicians, Diagnostic services, Consultants, Facility Patient Flow, EMS Program, etc.</p> <ul style="list-style-type: none"> Implement IFT Program Oversight Implement IFT Program Issue Resolution 	<ul style="list-style-type: none"> The IFT program would be clinically and operationally evaluated and support IFT cost reduction targets, patient flow targets, ED wait time reduction targets, diagnostics and specialized services wait time reduction targets, etc. 	Year 3

Developing a Provincial Approach to Advice and Service Coordination

The high volume of urban and rural patient transfers and the resulting repatriation is straining the system and can be addressed by introducing a provincial approach to advice and service coordination among physicians and clinical teams.

This service will decrease a portion of this volume and associated costs, while providing support and coordination services to ensure the patient transfer is appropriate, the patient is being referred to most appropriate location and service, and via the most appropriate mode of transport, with the most appropriate medical escort and priority.

Current state challenges

Disruption to ED Physicians and Referring Physicians & Providers

Before a patient is transferred, the referring physician/clinician is expected to contact the receiving facility/physician prior to arranging transport.

Multiple attempts/calls are frequently required to complete consult and transport coordination

Inappropriate use of ED Resources in Winnipeg

Approximately 25 rural IFT patients are received daily in the HSC Emergency Department (15% of the total ED volume) and require the ED Physician to coordinate the care required for the IFT patient (full assessment, diagnostic and consultation orders)

Lengthy wait for Specialist Consults, Diagnostic Testing and Specialty Treatment

IFT patients compete with higher-acuity Emergency Patients for these slots which can lead to delays that affect ED Patient Flow and inhibit the potential same-day repatriation of IFT patients to their home hospital

Rural Recruitment & Retention

Access to physicians and specialty staff is limiting recruitment and retention of clinicians in remote areas.

The 2017 Wait Times Reduction Task Force Report recommended implementation of a Provincial Emergency Coordination Service to address these issues

Management of IFT Continuity of Care

No process or safety tool exists to document or manage communication or care planning between providers and/or facilities

No line of sight on patients being transferred between facilities or from primary care to EDs via taxi or own transport (Brian Sinclair Report Recommendation)

Implementation of a provincial approach would reduce some transfers of stable, non-complex patients by supporting providers with emergency physician consultation services for local care options and care delivery. In addition to decreasing the volume of patient transfers, this will:

- Provide direct access to emergency medical specialist physicians to aid providers in diagnosing patients and determining an appropriate plan of care
- Release ED Physicians from providing phone consultation services to enable more time providing direct care to Emergency Department patients
- Provide continuity of patient care (and care planning) between hospitals, enabling better alignment and scheduling of appointments for IFT Patients
- Eliminate the need for the referring provider to work directly with IFT coordination services while ensuring proper use of transport and resources
- Provide oversight to ensure the appropriate IFTs are being prioritized for transport, and the transport mode and any specialty escort needs are met
- Provide the health system with quantifiable information on health service deficiencies that require transfer of the patient to meet their health care needs

Developing a Provincial Approach to Advice and Service Coordination

A provincial approach to advice and service coordination will provide a single point of contact to support the assessment and coordination of patient transfers as well as provide ongoing/real-time clinical support to rural physicians, nurse practitioners, nurses and other healthcare staff, including paramedics in all regional health authorities. Four initiatives are prioritized for initiation over the next three years:


Initiative	Key Considerations	Timeline
<p>1. Shift from emergency department physicians providing assessment and consultation for Inter-Facility transfers to a coordinated centralized service with direct access to emergency physician specialists, and coordinated access to other specialty and critical care physician, nursing and allied health consultants, supported by a common platform with access to relevant HIS (hospital information systems) like EPR, EDIS, RIS/PACS</p> <ul style="list-style-type: none"> Establishment of electronic Interfacility transfer care and treatment planning will support continuation of care 	<ul style="list-style-type: none"> Transfer requests validated Transport priority/method/medical escort appropriate Care plan developed/initiated Pre-Scheduled diagnostic/consult appts. Digital enablers for virtual consultations Monitoring safe transfer of patients not arriving via Patient Transport service 	Year 1-3
<p>2. Establish a Provincial Resource Team to provide a consultation service with a single point of contact for all providers in Manitoba through centralized access</p> <ul style="list-style-type: none"> 24/7 Emergency Physician Specialists IFT specialist coordinators to triage transfers requiring physician consultation and coordinate inter-facility transportation resources 	<ul style="list-style-type: none"> Information Management system to record all contacts and care plans Pre-registration of patient to receiving facility; electronic/manual order entry for scheduled diagnostics 	Years 1-3
<p>3. Implement Infrastructure to support call-taking, enable access to regional electronic health record systems and develop electronic documentation to support physicians and coordinators to efficiently and effectively manage Inter-Facility transfers and coordination of care between facilities.</p>	<ul style="list-style-type: none"> This infrastructure should be accessible from wherever it is deemed the physicians and call coordinators will be physically located to enable them to provide real-time, ongoing consultation 	Years 1-3
<p>4. Establish Governance and Management Oversight to this provincial service as well as escalate issues and concerns to areas supporting IFT patients</p> <ul style="list-style-type: none"> Program will work directly with diagnostic service areas and consultants to ensure the effective coordination of services Program will work directly with facility patient placement/bed coordination/patient flow coordinators to identify those patients that will require inpatient stay and plan for their arrival as well as repatriation back to the home facility if/when required 	<ul style="list-style-type: none"> The program would be clinically and operationally evaluated and support IFT efficiency targets. The program would be able to identify (and quantify) specific areas of investment in local health services that would reduce or eliminate patient travel to have health care needs met 	Year 1-3


Building for the Future


Call to Action – Achieving the Clinical and Preventive Services Plan

Manitoba's health system has the opportunity to capitalize on the momentum, positive energy and system-wide anticipation generated through the development of the CPSP. The process has been collaborative and transparent and sets the foundation for action over the next five years. This CPSP sets the course for immediate implementation and will guide the work of health system providers, agencies and government across disciplines and sectors. A process to continually refresh and enhance the plan will be required.

A high-level initial roadmap will guide this work. The roadmap incorporate the following recommendations, each of which is necessary to ensure success:

 **Develop and Commit to Provincial Clinical Leadership and Governance and Quickly Action Near-Term Clinical Improvements**
Provincial Clinical Governance is critical to the long-term success of the plan. Early initiation will provide the necessary leadership and insight to providers across the province. Early execution of targeted clinical practice improvements will catalyze the role of provincial governance and result in early patient care success.

 **Commit to a Modernization of Care Provided in the Home and Community**
Enhancing home and community care requires a standardized and modernized provincial model that reflects a new approach to care design and delivery and which aligns capabilities, incentives and accountabilities. This will need to include an enhanced workforce plan for this sector and will be enabled by digital health capabilities and appropriate clinical supports. Care provided in the home and community will better support patients and their families in their home communities and is an exciting area of opportunity for Manitoba.

 **Shift to a Provincial Clinical Network Model to Align Capabilities to Community Need**
Shifting to the Provincial Clinical Network provides a provincial approach to decision making and care delivery that matches community needs with capabilities. The shift is enabled by digital health capabilities, alignment of health human resources, change in approach to care delivery, better connectivity between providers and communities, and appropriate clinical supports such as diagnostics and EMS.

The Provincial Roadmap aligns prioritized clinical enhancements and investments on a provincial basis.