Provincial Chronic Disease Management Program
TeleCARE TéléSOINS Manitoba

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What is TeleCARE TéléSOINS MB

- TeleCARE TéléSOINS is a chronic disease self management program designed to provide support to Manitobans in their communities/homes.
- The program evolved from the Patient Access to Quality Primary Care/CareLink (PAQC/CareLink) initiative.
- One of the goals of the PAQC/CareLink project was to improve after hour access to primary care and to provide qualified support for patient’s self-management of chronic conditions.
- Currently, the focus of the program is on Heart Failure and Diabetes. A future goal is to expand to include other chronic diseases such as COPD and Renal Failure.
Current Program

- Heart Failure program continued after pilot project was completed.
- Program expanded to all regions of Manitoba.
- In 2009 Diabetes was added as the second disease state.
- Staffing was increased to accommodate the increased participants.
TeleCARE TéléSOINS MB Program

- Referral - from health care provider or self
- Intake - eligibility, willingness to participate
- Clinical profile - history, medications, procedures, reactions and risk factors
- Assessment - risk stratification
- Monitoring and education
- DM - graduation or continue on in program
- CHF monitoring
Who is Eligible to Participate?

- Heart Failure:
- Adults, 18 years of age or older, who reside within the province of Manitoba
- Participants must have a health-care provider willing to collaborate in management of care
- NYHA Class I – IV
- Functionally able to participate in telephone or telehealth-based health-care delivery
Who is Eligible to Participate?

- **Diabetes:**
  - Adults, 18 years of age or older, who reside in the province of Manitoba
  - Diagnosed with Type 2 diabetes with an A1C of < 9% and taking two or fewer oral agents (not on insulin) OR
  - Identified as having pre-diabetes OR one or more of the following risk factors: strong family history of diabetes, history of gestational diabetes or diabetes in pregnancy
  - Not currently pregnant at the time of enrollment
  - Not currently accessing other diabetes resources
  - Ongoing diabetes care is provided by a health-care provider who is willing to collaborate in shared-care management
  - Functionally able to participate in telephone or telehealth-based health-care delivery
Referral form

TeleCARE TéléSOINS Manitoba
Program Referral Form

Program requested: HEART FAILURE _____ DIABETES _____

Client Name: _________________________________________________

Mailing Address: _______________________________________________

Phone Number: ________________________________________________

Date of Birth: ______________________ P.H.I.N. ____________________

Referred by: _______________________ Phone: ______________________

PCP Name: _______________________ Phone: ______________________

Fax: ________________________

Hgb A1C _____ Date _____ (within 6 months, mandatory for Diabetes Program)

Lipid Profile: (within 12 months preferred) Date _____

T. Chol ____ HDL ____ LDL ____ Trig ____ Ratio ____

Medical History:

Medications:

Please complete all fields on referral form and fax to 204-779-5645. If you have questions, please call 204-788-8688 or toll-free at 1-866-204-3737. Additional copies of this referral form are available at:

Risk Stratification

- Participants answer questions and their level of risk is assessed; low, moderate or high.
- Calls are scheduled based on this risk level.
- Risk is assessed based on clinical history, medications, present symptoms, determinants of health, lifestyle choices, ability to care for oneself and access to support.
- Participants can move between risk levels.
Key Program Features

- Intervention – Customized self-management plan
  - Proactive condition related education, discussion and support
  - Educational mailings (Care Plans, Pamphlets, Workbooks)
  - Alert providers based on clinical monitoring
  - Referral to local support sources
  - Symptom based triage 24/7 through relationship with Health Links- Info Santé
Client Health Education Topics

- Heart Failure and Diabetes Basics
- Nutrition Counseling- with Dial-a-Dietitian
- Home Monitoring
- Medications
- Preventative Measures
- Exercise

*all education is evidence based and follows best practice from accredited sources including the Canadian Cardiovascular Society, Canadian Diabetes Society and the Canadian Hypertension Society.
Current Status of the Program

- Enrolment Statistics - as of December 2018
  - Heart Failure Patients – 62 rural, 173 urban = 235
  - Diabetes Patients – 42 rural, 130 urban = 172
  - Telehealth videoconferencing available for those without phone access
  - Communication tools available
  - Partnerships with existing diabetes and heart failure resources for patient identification and referral
Questions?

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