

TeleCARE Manitoba

Working Together to Manage Heart Failure

HEALTH-CARE PROVIDER FACT SHEET

The TeleCARE Manitoba program is an expansion of the successful, comprehensive self-management program for heart failure.

Utilizing evidence-based protocols for the management of heart failure (HF) in collaboration with the clinical team at the St. Boniface Heart Failure Clinic, the teletriage team will assess, monitor and teach self-management to Manitobans with HF.

By telephone or MBTelehealth's videoconferencing services, a program nurse will conduct a comprehensive assessment with each participant. During the assessment, program nurses:

- ▶ Collect and document all pertinent medical history, medications, past procedures, and clinical risk factors
- ▶ Determine the level of support required based on the patient's health status
- ▶ Provide health education on self-management of HF as well as contributing co-morbid conditions
- ▶ Establish a personalized call-monitoring schedule
- ▶ Undertake goal setting and management with the patient

Health education files, literature and brochures are sent to the patient based on the initial assessment and stratification level, and as required, throughout their program participation.

Based on the nurse's clinical assessment at each patient interaction, appropriate actions are taken (informed by the clinical data, protocols, standing medical orders, and/or in consultation with the primary health-care provider).

Patients are re-evaluated and re-stratified every six months using the assessment process and will have their monitoring program modified accordingly. Patients are also invited to call the program nurses at any time should problems arise between regularly-scheduled calls.

Eligibility criteria:

- ▶ 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 videoconference-based (via MBTelehealth) health-care delivery
- ▶ No significant visual, cognitive or physical impairment without a supportive family member who is actively involved in the provision of care

HEALTH-CARE PROVIDER BENEFITS

- ▶ The program team will assist you in dealing with the increasing burden of chronic disease
- ▶ Fewer hospital admissions and ER visits
- ▶ Care mapping for standardized care of Manitobans with HF as outlined by the Canadian Cardiovascular Society with target doses for medication and criteria for specialist referral
- ▶ Optimal utilization of specialist appointments
- ▶ Patient education on medication, nutrition, exercise and self-management which increases patient compliance
- ▶ More focused office visits

PATIENT BENEFITS

- ▶ Increased knowledge of HF and symptom awareness
- ▶ Improved quality of life, mental health, activity tolerance, and better health outcomes
- ▶ Coaching and guidance for weight reduction, smoking cessation and co-morbid conditions
- ▶ Increased access to medical care and communication with health-care providers available 24/7 throughout the course of illness
- ▶ Assistance with access and referral to other health-care professionals as the need arises
- ▶ Health care provided in the comfort of patient's home via telephone, or at a local MBTelehealth site through videoconferencing services, with the inclusion of other family members as requested by the patient

To contact the program team, obtain patient brochures, or to make a referral to this program, please call 788-8688 or toll free at 1-866-204-3737 or fax a referral to (204) 779-5645.
www.gov.mb.ca/health/phc/telecare

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