Advancing a Population Health Needs Framework: Progress and Future Directions

A Task Force Update (Part 2)

This presentation will be recorded

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Alberta Health Services
Primary Health Care Integration Network

Alberta Health Services
Population, Public & Indigenous Health SCN™

Inspiring solutions. Together.

Today's Speaker: Jacqueline Krysa, PhD, Scientist, Primary Health Care, AHS

Acknowledgements

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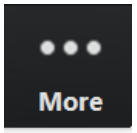
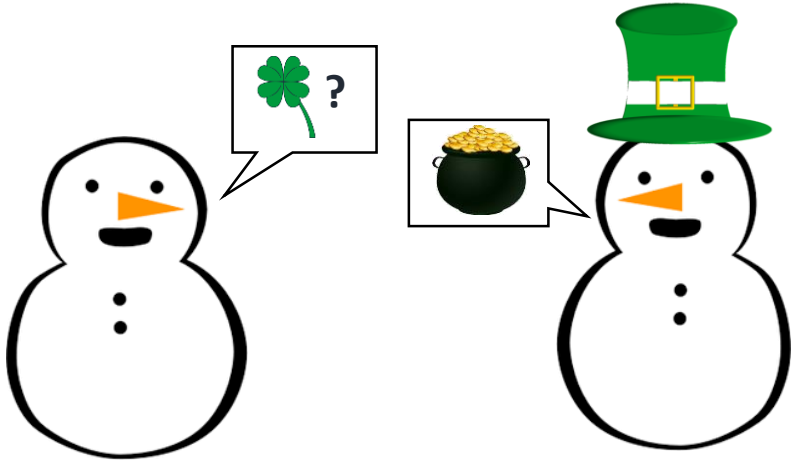
How You Can Participate: Chat

You can type questions in the chat panel, under

'More'





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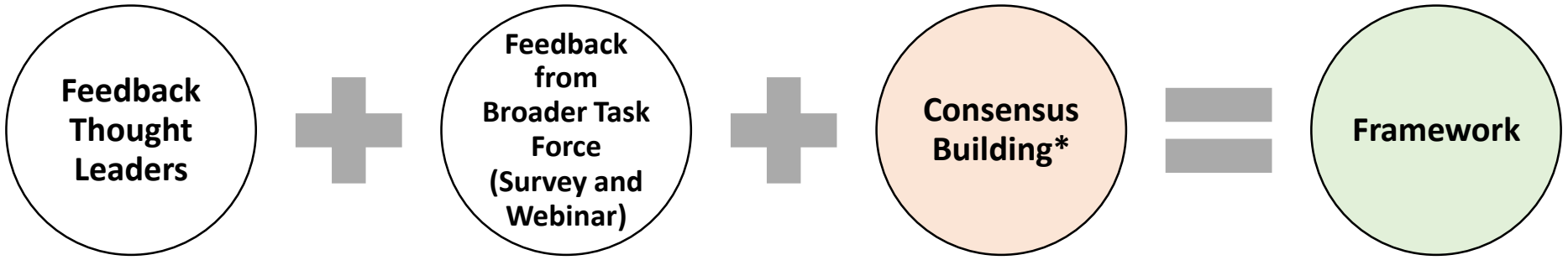
Population Health Needs Framework: Update and Discussion (Part 2)

Empathy: The Human Connection to Patient Care: https://www.youtube.com/watch?v=cDDWvj_q-o8

Recap: Framework Development Process



January 2020

- How to make the framework operational?
- How to advance inter-sectoral partnerships?

- Definition, domains, and enablers

March 2020

- In-person testing
- Patient engagement

*Community, PCN, SCN, AHS

Delphi Methodology to Build Consensus

- Approached n=40 individuals across portfolios: AHS, SCN, community, and PCN
- Participants provided rankings and feedback for 3 rounds until consensus was reached for all categories
- Received rankings and constructive feedback from:
  - n=17 (round 1) (12% community agencies; 24% PCN; 65% AHS
  - n=10 (round 2) (20% PCN; 80% AHS)
  - Round 3 is being completed this week
- Result:
  - Service planning definition for population health needs
  - Framework domains
  - Essential enablers

Service Planning Definition of Population Health Needs

"Addressing health needs requires an understanding of what matters most to the individuals who live, work, and play in communities across Alberta. When service planning is based on what matters most to our communities, it shifts the focus towards supporting health equity and wellness (wellbeing) over the life course…

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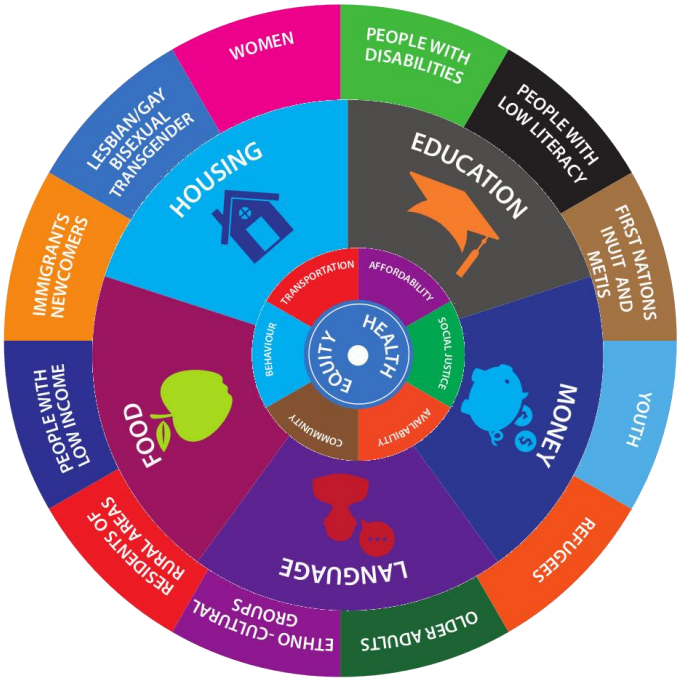
Service Planning Definition of Population Health Needs

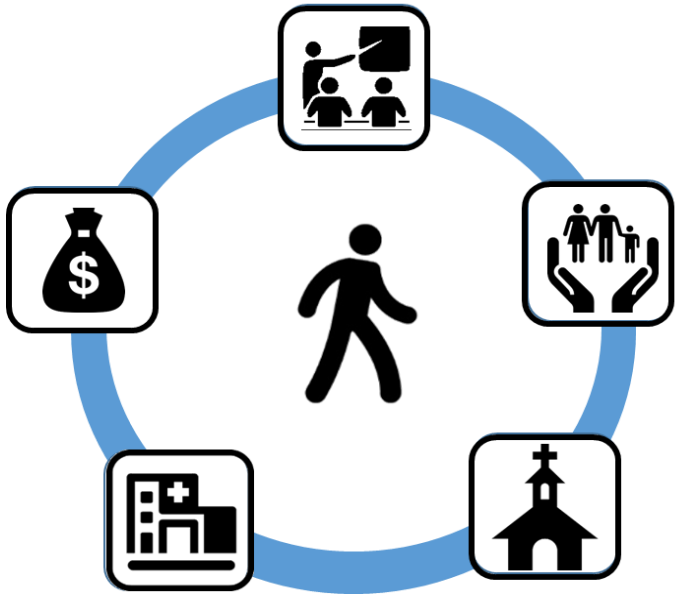


Domains

Health needs broadly relate to physical, biological and mental health, built environment, social environment, climate and natural environment, community adaptiveness and resilience, and the socioeconomic and political context…

Image taken from: https://www.publichealthgreybruce.on.ca/Your-Environment/Healthy-Communities/Health-Equity#Money

Service Planning Definition of Population Health Needs



Enablers

Service planning across sectors is enabled by appropriate governance and pre-existing structures, collective impact, collaboration, and continuity and coordination of care".

Image taken from: https://www.publichealthgreybruce.on.ca/Your-Environment/Healthy-Communities/Health-Equity#Money

Domains

Physical, Biological, and Mental Health

- e.g., chronic health conditions, genetics, disability, ethnicity, age, mood disorders,, physical activity, nutrition, health promotion activities, psychological wellbeing, coping, resilience, sleep quality, self-actualization

Built Environment

- e.g., physical structures, schools, recreation facilities, sidewalks, transportation, cross-walks, access to natural areas, access to safe water sources

Social Environment

- e.g., social networks, social institutions, social participation, social stigma, social inclusion inter-generational considerations, gender, cultural identity, spiritual wellness, social awareness, life-stage transition, relationships, safety

Community Adaptiveness and Resilience

- e.g., community viability , readiness, community engagement, engagement, development of community resources, bridging and connection (e.g., cultural language)

Socioeconomic and Political Context

- e.g., housing, environment, income, employment, education, food insecurity, social procurement

Climate and Natural Environment

- e.g., air pollution, clear drinking water, natural disasters, health consequences of climate change

Appropriate Governance and Pre-Existing Structures

Strategies

1. **Make population health needs a strategic priority**

   e.g., Effective population health based strategies are embedded within an organization's strategic direction

2. **Create opportunities to support population health**

   e.g., Appropriately connect care teams at the community level to ensure that care teams better support the whole person

3. **Capacity building**

   e.g., Identify which education and resources will be needed based on the population receiving care

Collective Impact and Authentic Collaboration

Strategies

1. **Identify Appropriate Partners**

2. **Create a shared vision**

   e.g., Identify the mutual benefits for partners from all sectors that can arise from collaboration

3. **Establish common measures**

   e.g., Determine which organizations and agencies can provide the best input and information needed to assess and address the priority area of interest

4. **Resource mutually reinforcing activities to improve community resilience**

   e.g., Develop and support tools at the community level that enhance community resilience across settings and services

5. **Support continuous communication and engagement with partners**

   e.g., Promote innovation in communication by co-creating partnership agreements

6. **Determine a backbone organization to guide vision and strategy**

Continuity & Coordination of Care

Strategies

1. **Strengthen the relationship with providers and provider relationships**
   e.g., Leverage and coordinate resources within existing partnerships

2. **Define roles and responsibilities**

3. **Provide comprehensive care**
   e.g., Support and participate in a local inter-professional care teams to provide broad range of services

4. **Appropriate technology supports**

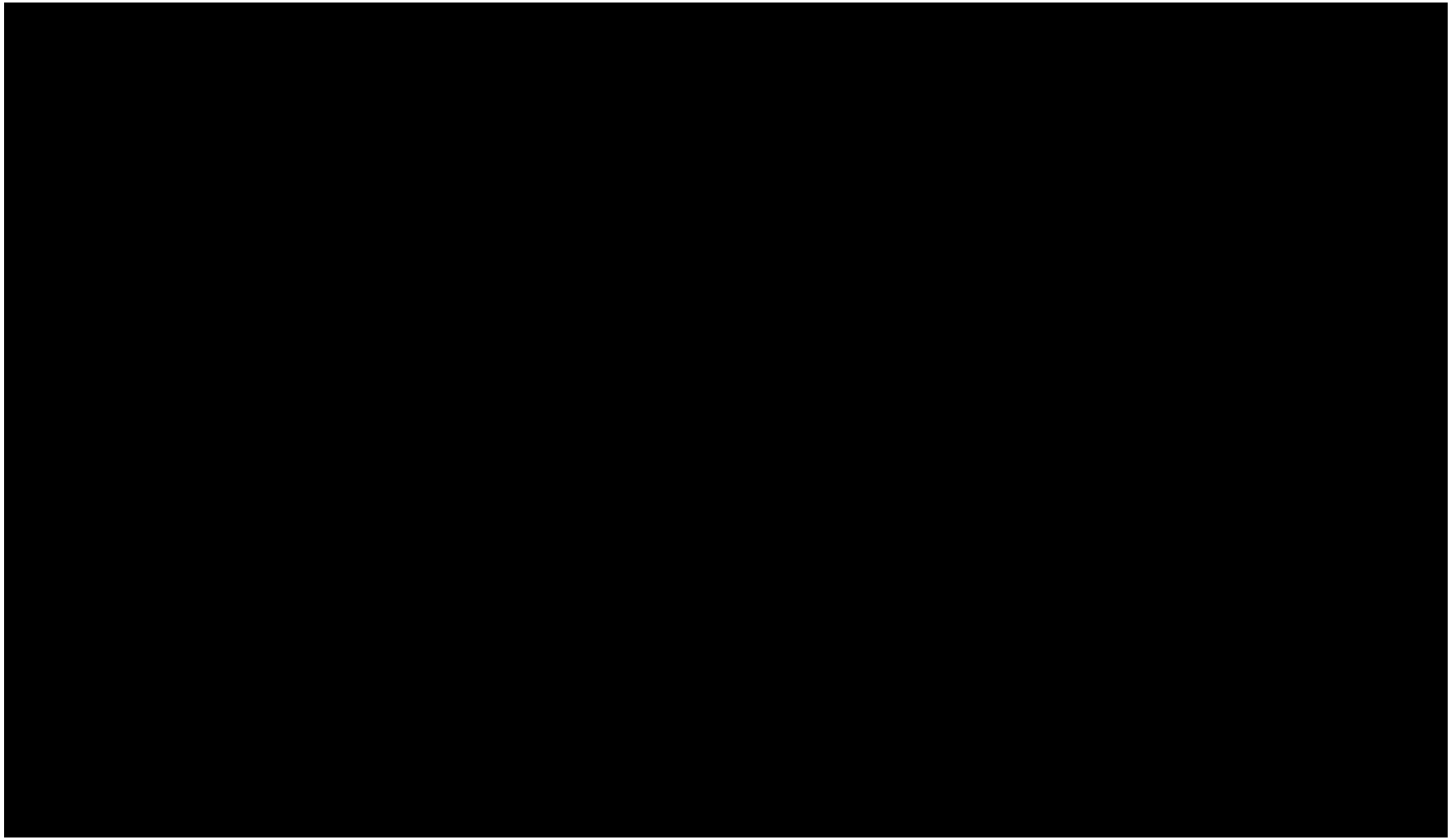
Usability Testing: In-Person Design Days

Objectives: (1) Test the framework prototype for usefulness; (2) Understand how the framework will be used in practice

1. **February 27th (3:30-5:40pm)**
   - Focus on capturing the lived experience and creating 'personas' and 'journey maps' based on these experiences
   - **Front-line service providers**, intergroup agencies, joint service planning

2. **March 4th (3:30-5:40pm)**
   - Identify and prioritize needs using the framework prototype for service planning and understand the enablers to undertake planning strategies
   - Managers, executive directors, leadership, intergroup agencies, joint service planning

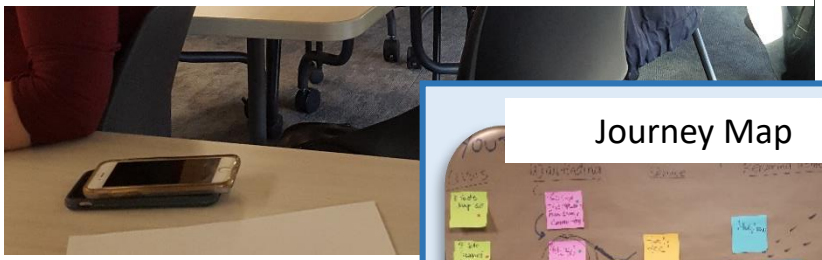
Population Health Needs Framework: Update and Discussion (Part 2)

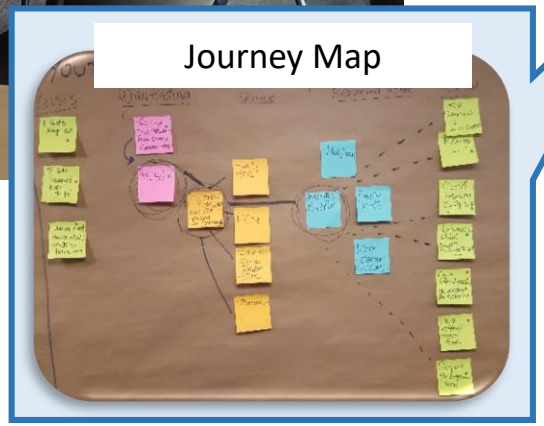


Video link: https://www.youtube.com/watch?v=qasZ0OW8sMo#action=share

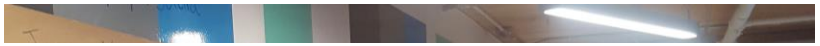
In-Person Design Days: Day 1

Sharing experiences and learning about human-centered design





Journey Map



Creating Patient Personas and Journey Mapping

Pictures were taken and presented with consent from participants

Persona Created from Day 1

Eralia: A Fictional Persona

Biography

Single parent; recently abandoned by her husband
Only been in emotionally abusive relationships since
Three children: age 21 moved out and is unemployed, the other two are 16 and 10 years old, living at home
Works as a cleaner – low income with no benefits
Ill health; overweight and dealing with recent type 2 diabetes diagnosis

"I don't know how or where to find help… How will I support my children when I can't event take care of my own health?"

Obstacles + Challenges

- Caring for her family as a single parent
  - Trying to help her kids assimilate into Canadian culture without having been in Canada for very long
  - She can only afford to be in government housing (unsafe area, worried her children may be exposed to bad influences)
- Health Concerns
  - Difficulty managing cost of diabetes medication
  - Worried her health condition may deteriorate due to physically demanding job and being overweight (chronically fatigued and stressed)
- Earning a Living
  - Current job as a cleaner is tiring and comes with no benefits (often requires working night-shifts)
  - Current income is not enough to support her and her children
  - Post-secondary education is not transferrable and she does not have professional working
  - She doesn't have professional working English language skills, further limiting her job options

Fears and worries:

- Not being able to support her children and having them fall "into the wrong crowd"
- Having to depend on an unsupportive / unstable partner for financial needs
- Unable to go back home to see her family
- Health concerns taking over her life, and not being in control of her health

Social Circle + Resources

- Isn't aware of resources to find a physician for her diabetes, weight, or mental health concerns
- Outside working and taking care of her children, she doesn't have time for meeting new people

Priorities + Goals + Values

- Hopes to provide a good future for her children
- Wants to get accustomed to Canadian values but has little time outside work and home
- Wishes to go back home to see her family one day

Design by Calvin Chan and Zeenat Ladak

Journey Map Created from Day 1

Eralia's Fictional Journey

Stages

Crisis | Wayfinding | Accessing Services | New Normal

Touchpoints

Eralia is Diagnosed with Diabetes

After multiple dizzy spells at work. She goes to her family physician who diagnoses her with diabetes

Finding the Right Resource

Worried about her physically demanding work and deteriorating health , Elaria turns to neighbors in housing complex for support

They suggest she look up Multicultural Health Brokers Co-op (MCHB)

Contacting MCHB

Elaria looks up MCHB at her library.

Takes the bus/LRT to have her first Consult with MCHB

Eralia meets the MCHB team

They assign her to multiple health brokers including: family physician, dietician, social worker, & pharmacist who speak Hindi

Working with MCHB

The MCHB brokers help Elaria's through providing emotional counseling, teaching her about nutrition and diabetes management, helping her practice injury prevention exercises, and finding healthy and affordable groceries

Elaria to her normal routine

Elaria practices the advice she received from MCHB to protect her physical and mental health

Small step

Even with MCHB, Elaria still isn't able to address all of her financial concerns: she isn't able to consistently afford medication or healthy food options. Her job as a cleaner remains physically demanding and exhausting

Thoughts and Emotions

Feeling regretful but powerless

"I should have taken care of my diet more. But how could I have known this was going to happen?"

"I can only provide for myself and my family what I can afford."

Anxious but hopeful

"I am really not sure what to expect….but hopefully I can learn something from them. They are immigrants just like me."

Anxiety and worry

"I hope my kids will be okay alone at home, I am not sure I will be back in time to walk them home from school."

"Do I have enough bus tickets?"

Feeling optimistic

"Finally a doctor who can speak Hindi! Someone who can understand where I am coming from and will be able to give me advice."

Feeling thankful

"I can use these tips to to protect me and my children's health now!"

Back to reality

"I know medicine and healthy food is important, but I cannot always afford it."

"Somedays it feels like life never really changes…"

Design by Calvin Chan and Zeenat Ladak

Use a broader population health needs lens versus your clinic or organization lens

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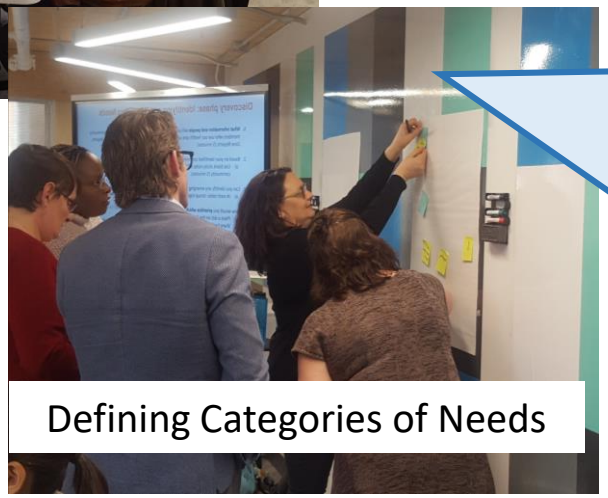
In-Person Design Days: Day 2

Facilitated group discussions on how to identify community needs?



Defining Categories of Needs

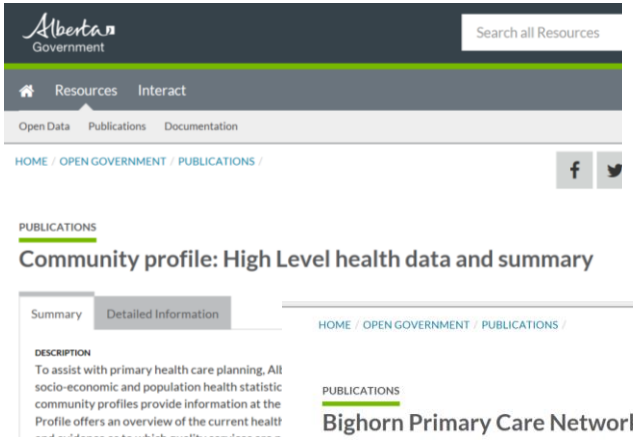
Identifying Priority Needs

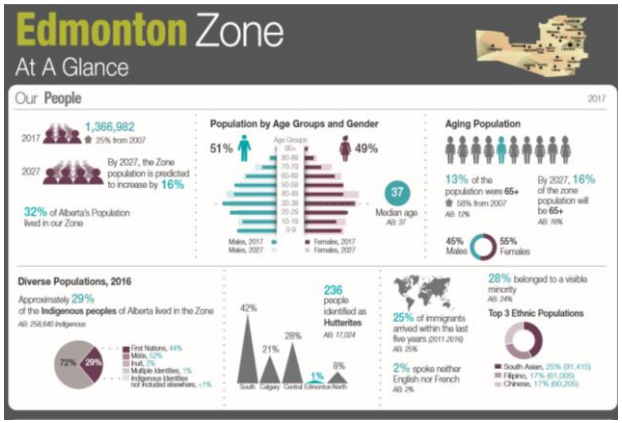
Pictures were taken and presented with consent from participants

Chat

Use the chat box to say what information, resources and people you have used or have seen others use

How do you understand the **needs** of community members who use or access our services to be well? e.g., Personas, Journey Maps, Community Reports, Zone Reports





Feedback from In-Person Design Days

Who is missing from the table when planning for population health needs?

- Patients, Individual community members
- Police services
- Social workers/case-workers

What did you learn?

- "the issues and challenges across sectors are the same"
- "Re-learning illness versus wellness"

Next Steps for the Framework?

- Share with colleagues
- Support non-profits in identifying other players and transitions to more collaborative work groups
- Useful for volunteer organizations to craft volunteer positions that are better able to respond to trends/barriers to engagement

Patient Engagement Activities

- Holding two online engagement sessions with two Alberta Health Services patient advisory groups:
  - Provincial Patient and Family Group (comprised of 25 patient advisors across the province)
  - The Virtual Patient Engagement Network (comprised of over 100 patient advisors across the province)

- **Purpose:** to understand the relevance and usability of the framework at the patient-level

Deliverables for March 31st, 2020

1. 2-page framework (use in-person)
2. User's Guide (Guide and Workbook)
   - This will guide users on how to use the framework to begin identifying and planning for population health needs, including how to build and maintain relationships amongst care sectors
3. Website 'together4health' is being used to continuously update framework

Thank you for being part of this journey

jacqueline.krysa@albertahealthservices.ca

Reducing the Impact of Financial Strain

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Primary Health Care Integration Network

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Where to Find More Information on this Work and Other Projects Related to Financial Strain?

https://together4health.albertahealthservices.ca/FinancialWellness

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