Population Health Needs Framework for Service Planning

Alberta Health Services

ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

Primary Care Networks

Introduction

Service planning is “a deliberative process through which decision-makers plan where and what health services will be delivered in a jurisdiction.” In Alberta, healthcare service planning decision-makers do not use a consistent approach to address the health needs of Alberta’s populations in their planning processes. Often, healthcare service planning is based on healthcare utilization rather than what matters to the communities and population we serve. Therefore, the aim of the co-developed population health needs framework is to support decision makers (i.e. any stakeholder, service provider, or service partner involved in service planning) and identify opportunities to improve health and well-being of Albertans and their communities.

It is envisioned that the Population Health Needs Framework for Service Planning and its accompanying User’s Guide will be used by AHS Zone, PCN, and community partners to jointly plan services across the continuum of care. The purpose of the framework overall is to help identify and address population health needs and plan services by shifting away from a medical focus towards wellness, while improving population health outcomes and supporting health equity.

Framework Objectives:

1. To create a common agenda (e.g. understanding of health needs; service planning processes; application to a variety of health agencies, services, and programs).
2. To develop a shared measurement system that uses a common set of indicators to monitor performance of population health and health of populations, inform service planning, track progress, and promote improvement and accountability.
3. To align and coordinate mutually reinforcing activities across sectors (i.e. serve as a guide for service planners).

Findings from the academic literature, grey literature, an interview analysis, and a Modified Delphi process were used to identify essential elements of population health needs. From this process, six domains of population health needs, which are broad determinants proven to influence health, were identified. The Population Health Needs Framework for Service Planning has been structured around these six domains.

To further support users of the Framework, this user guide was created. The guide provides activities and tools such as coalition building; journey mapping; and personas that healthcare, social services and community stakeholders can use together to identify and prioritize what matters most to community members.

The following two pages were created to guide stakeholders and partners as a standalone document during service planning.

How might we plan for services that address population health needs?

Identifying and addressing population health needs requires an understanding of what matters most to the individuals who live, work, and play in communities across Alberta.

When services are planned based on what matters most to our communities, it shifts attention away from a medical focus towards wellness (well-being) over the life course while improving population health outcomes and supporting health equity.

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

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

Population Health Needs: Identifying and addressing population health needs requires an understanding of what matters most to the individuals who live, work, and play in communities across Alberta. When services are planned based on what matters most to our communities, it shifts the focus towards wellness (wellbeing) over the life course while improving population health outcomes and supporting health equity. Health needs broadly relate to physical, biological and mental health, built environment, social environment, natural environment, community adaptiveness and resilience, and the socioeconomic and political context. Service planning across sectors is enabled by appropriate governance and pre-existing structures, collective impact, collaboration, and continuity and coordination of services.

How to Begin Addressing Population Health Needs

Consider the following high level questions to consider as you begin planning services appropriate for your community and determine where it makes sense for you to begin the conversation. All questions are important for addressing population health needs, but the order in which they are considered and/or enacted will vary by context and across organizations and partners in service planning.

WANT TO LEARN MORE? See the Population Health Needs Framework User's Guide

Domains of Population Health Needs

Physical, Biological & Mental Health

Healthcare services, chronic health conditions, genetics, disability, ethnicity, age, mood disorders, trauma-related disorders, physical activity, nutrition, health promotion activities, psychological wellbeing, coping, resilience, sleep quality, self-actualization

Natural Environment

Clean air, reduction of green-house gas emissions, natural disasters, climate change, clean drinking water

Built Environment

Physical structures, schools, recreation facilities, sidewalks, active transportation, cross-walks, access to natural areas, access to safe water sources

Social Environment

Social networks, social institutions, social participation, social stigma, social inclusion, intergenerational considerations, gender, cultural identity, social awareness, spiritual wellbeing, life-stage transition, relationships, safety

Community Adaptiveness & Resilience

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

Socioeconomic and Political Context

Income, employment, education, food security, racism, colonialism, governance, public policies

Figure Adapted from National Association of Community Health Centers PRAPARE Toolkit[1]

DOMAIN

Physical, Biological & Mental Health

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

Description of Domain:

The individual factors that impact physical, biological, and mental health and influence the discrepancy between one's health, desired health status, and the ideology of living well. These factors are complex and interconnected. They are also influenced by health beliefs, as well as intentional or unintentional actions that influence health, sensitive periods throughout the life course, and the social and physical environment[2].

Related Domains:

Objectives:

1. Care organizations, care providers, and care teams provide acceptable, accessible, and appropriate care programs and services tailored to account for differences in health outcomes that arise from individual factors and critical periods of development (e.g., early childhood development). These programs and services can positively influence biological, physical, and mental health[3] and result in greater well-being for the individual receiving care.
2. Care organizations provide effective, safe, appropriate, holistic, and integrated care, focusing on preventative strategies that promote healthy lifestyles and reduce or manage chronic conditions. These strategies take into account cultural and developmental needs/abilities, as well as influencers of self-management behaviors[4].
3. Care providers and care teams recognize the influence and ability of social, built, and natural environments to enhance care continuity to improve prevention and management of disease and improve health quality of life[5].

DOMAIN

Natural Environment

Clean air, reduction of green-house gas emissions, natural disasters, climate change, clean drinking water.

Description of Domain:

The larger ecological context individuals, communities, and societies are contained within. Man-made or natural consequences from the ecosystem have a significant impact on individual, community, and societal well-being.

Related Domains:

Objectives:

1. Care organizations, teams, and providers partner with communities impacted by adverse temperature changes and natural disasters to provide acceptable, appropriate, and safe relief services to affected individuals and families (e.g., health system emergency and disaster management, emergency shelters, rescue and evacuation services, food, emergency medical services)[6].
2. Care organization resources (i.e., time, people, funding) are optimally used to address health problems accelerated by climate change and natural disasters (e.g., lower respiratory infections, asthma, heat stress)[15].
3. Care organizations work in partnership with communities to mitigate and respond to risks from climate change and natural disasters (e.g., threats to food security, water shortages, avoidance of infectious diseases)[6, 7].
4. Care organizations mitigate the unintended or harmful results of climate change by promoting efficient and effective environmental stewardship (e.g., changing hospital purchasing to promote sustainable food, limit toxic cleaning chemicals, and appropriate waste disposal)[8].

DOMAIN

Built Environment

Physical structures, schools, recreation facilities, sidewalks, active transportation, cross-walks, access to natural areas, access to safe water sources.

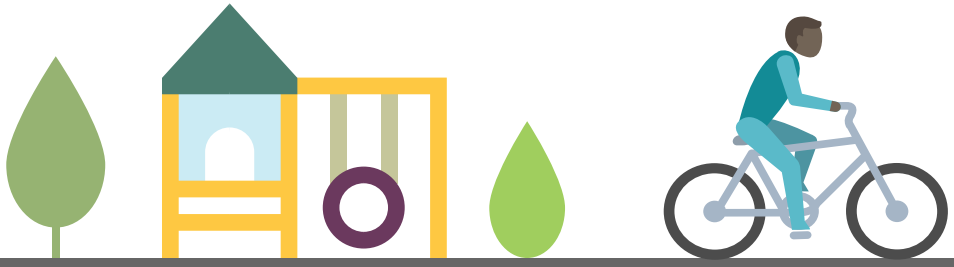
Description of Domain:

The physical surroundings and infrastructure that we encounter in our daily lives[7]. Individual conditions (e.g., disability, aging, living conditions) can alter the pressure the built environment has on overall health and wellness[8].

Related Domains:

Objectives

1. Care organizations and care providers collaborate with community members to assess the appropriateness and safety of their built environment (e.g., conditions in which they live, work, and play).
2. Care organizations and care providers increase the accessibility and appropriateness of their community infrastructure (e.g., sidewalk accessibility, affordable public transportation) by communicating and collaborating with local municipal government about health benefits of, and opportunities for, safe environments.



DOMAIN

Social Environment

Social networks, social institutions, social participation, social stigma, social inclusion, intergenerational considerations, gender, cultural identity, social awareness, spiritual wellbeing, life-stage transition, relationships, safety.

Description of Domain:

The quality of the social relationships and connections formed within our communities, as well as the social fabric and surrounding culture where we live, work, and play[9].

Related Domains:

Objectives:

1. Care organizations, care providers, and care teams increase the effectiveness of services by learning about family and peer networks providing support (emotional and informational) to their service users and promoting skill development among service users who need assistance engaging and maintaining social supports.
2. Care providers and care teams screen for social factors (e.g., owning a pet, social isolation, social supports) when they see patients and help address those factors (e.g., use a warm handoff to refer patients and follow through to ensure they receive appropriate community and/or social support).
3. Care organizations work with community members to enhance citizen participation in local recreational activities and cultural experiences through the development and promotion of acceptable and relevant community services.
4. Care organizations create opportunities for care providers and care teams to develop the appropriate skills they may need to work with groups stigmatized by health conditions (e.g., mental health, substance use disorder) or personal characteristics (e.g., gender identity, race, age)[9,10] to provide respectful, safe services to everyone[11].
5. Care organizations collaborate with social service providers to learn about social capital in local services and increase the efficiency of their services.

DOMAIN

Community Adaptiveness & Resilience

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

Description of Domain:

The resources, readiness, and capacities of communities to respond to adversity and change. Community members actively involved in the design and delivery of care services engage these community resources to thrive in environments characterized by uncertainty and change[12].

Related Domains:

Objectives:

1. Care organizations and teams provide appropriate services by continuously engaging with the community to assess their unique needs and ensure community readiness and safety to deliver programs and services (e.g., community needs assessment, changes in social policy) to enable community development, mobilization, and action to improve population health.
2. Care providers act as health advocates at the individual (e.g., referral to community supports), community (e.g., supporting a community health centre), and policy level (e.g., support policies that improve community well-being) for the quality and safety of the services provided in the community[13].
3. Care organizations and teams work with communities to strengthen resiliency and personal and collective capacity to influence change, sustain and renew the community, and develop new trajectories for the community's future[12].

DOMAIN

Socioeconomic and Political Context

Income, employment, education, food security, racism, colonialism, governance, public policies.

Description of Domain:

The broad range of personal, social, economic, and political factors in which people live, work, and play that influence individual and population health and well-being[14].

Related Domains:

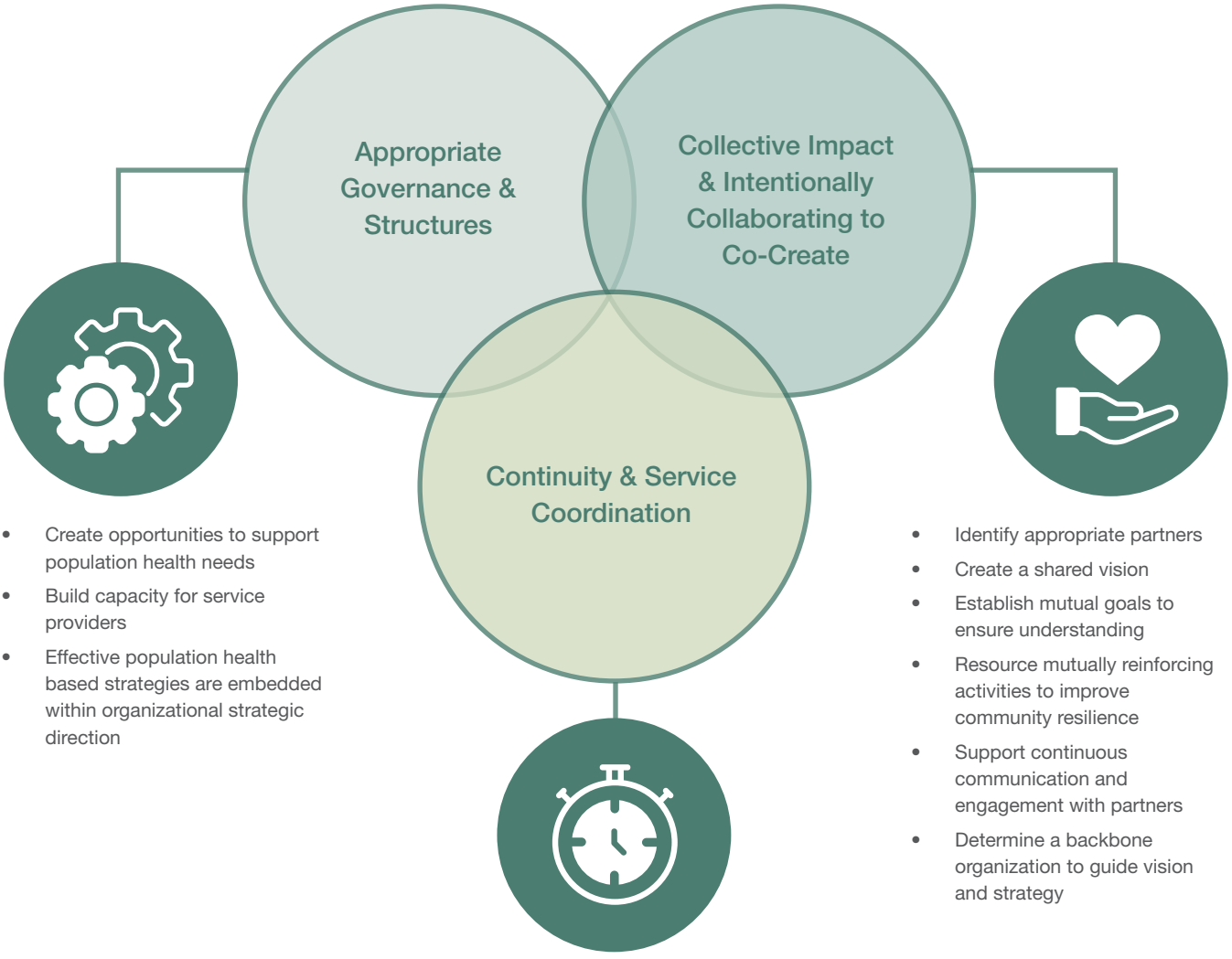
Objectives:

1. Care providers and care teams have access to appropriate training and resources needed to build their capacity to address the social determinants of health.
2. Care providers and/or care teams strive to effectively assess and address social determinants of health (e.g., income, education, housing, immigration status) at the individual, community, and policy level to address population health needs[17].
3. Leadership, care providers and/or care teams effectively identify and advocate for community members who are not having their needs met (e.g., complex, high needs populations).
4. Care organizations use data about marginalized/at-risk populations to ensure the services they provide are appropriate for the unique needs of the community[13] and to recognize differences within and between population groups to identify and address health inequities.
5. Leadership makes appropriate use of socioeconomic data to inform organizational strategic direction and service development. Leadership communicates priority needs to government to influence public policy initiatives to improve population health and well-being (e.g., education, taxation, health and social services).
6. Care organizations increase the efficiency of care services by making intentional, positive contributions to both the local economy and the overall vibrancy of the community[15].

Enablers of Population Health Needs

Enablers are how service delivery systems (i.e., community services, social services, health services) work together to prioritize and address health needs of individuals living in a geographic area. Within each enabler is a set of corresponding strategies and activities. These strategies and activities are optional as they may not be feasible for your role or organization. Simple actions can be taken today, while complex actions may be more feasible over time depending on political will within each organization. You may also wish to modify or add certain activities to suit your plan of action. It is hoped you find certain strategies and/or actions provided useful to begin planning and addressing population health needs.

Corresponding activities for each strategy can be found in the **User Guide**.



- Create opportunities to support population health needs
- Build capacity for service providers
- Effective population health based strategies are embedded within organizational strategic direction

- Identify appropriate partners
- Create a shared vision
- Establish mutual goals to ensure understanding
- Resource mutually reinforcing activities to improve community resilience
- Support continuous communication and engagement with partners
- Determine a backbone organization to guide vision and strategy

- Strengthen the relationship with providers and provider relationships
- Provide comprehensive care
- Develop appropriate technology supports

ENABLER

Appropriate Governance & Pre-Existing Structures

The systems, policies, and processes that give structure and support to an organization's key functions (e.g., financial and human resource support), which are in turn supported by a wide range of steering and rule-making related functions. Appropriate governance and structures support and promote population health needs and inter-sectoral collaboration in a participatory and inclusive manner through strategic direction, priority setting, and policy development[16, 17].

STRATEGY 1: Create Opportunities to Support Population Health Needs

ACTIVITIES

1. Create opportunities for community engagement to promote awareness of local community, social, and healthcare service organizations and the assets available within a geographical area (e.g., asset mapping, resource directories or library of services). (see Activity #1, 2, 3, and 4 and Reflective Exercise #4 in the User Guide)
    a) Invite community agencies, not-for-profits, and volunteer groups to talk to your care providers. This will help you understand what local services are available and how to connect patients to these agencies.
    b) Organize a round-table with decision makers from local agencies serving similar populations. (see Reflective Exercise #1 in the User Guide)
2. Appropriately connect care teams at the community level and across sectors (e.g., education and justice) to ensure care teams to support the whole person, inclusive of determinants of health.
    a) Develop opportunities and processes for connecting care teams at the community level to support teamwork across settings and services at the functional level[5]. (see Reflective Exercise #12 in the User Guide)
    b) Dedicate resources to support individuals needing services from multiple sectors (e.g., personnel, online-platforms, peer navigators, community health workers, social prescribing, link workers, care coordinators, case coordinators, health brokers, interdisciplinary professionals, physicians and team compensation)[5,18].

STRATEGY 2: Build Capacity for Service Providers

ACTIVITIES

1. Identify training, coaching, mentoring, and resources required for service providers to address population health needs[19] (e.g., Indigenous health, dementia training for transportation service providers). (see Reflective Exercise #8)
    a) Build awareness and capacity to support engagement, collaboration, and team-based care for your local populations through training/supports/communication.
    b) Enable team members to take training based on their skills and interests (e.g., develop communications website, community navigator, assign knowledge lead to ensure each provider has the same information).
2. Provide on-going training opportunities (e.g., a training website accessible for external audiences, internal and external training resources) and support providers to complete training (e.g., dedicated time to complete).
3. Provide opportunities to share successful ideas and/or strategies to promote spread and scale across the province.

STRATEGY 3: Effective Population Health Based Strategies are Embedded within an Organization's Strategic Direction

ACTIVITIES

1. Population health needs are appropriately linked to patient and family experience, patient and population health outcomes, experience and safety of our people, and financial health and value for money to help prioritize resource investments[20] (e.g., personas, empathy mapping, and journey mapping to include those at a disadvantage and individuals at higher risk in decision making to understand the resilience and adaptiveness of the community). (see Activity #1, 2, 3, and 4 and Reflective Exercise #4)

    a) Organizational changes appropriately align with the needs and desires of the community and the will of those who will be involved in implementation. (see Reflective Exercise #6 and 7) Communities are comprised of various interest groups, examples of which may include: local community or volunteer groups, faith based groups, cultural groups, virtual groups, and/or local residents[21].

    b) Care organizations plan acceptable services by enabling the community to advocate for their unique needs and validating those needs when planning for services. (see Reflective Exercise #6 and 7)

2. Staff communicate organizational gaps and recognized needs to leadership to promote changes that align with organizational strategic direction.

3. Decision makers promote and advance population health needs objectives within an organization, including backing community organizations, to better support the whole person and allocate appropriate resources to invest in population health. (see Reflective Exercise #1 and #13)

ENABLER

Collective Impact & Intentionally Collaborating to Co-Create

Care organizations work together with communities and local service organizations to pool their collective knowledge, resources, and skills to address population health needs, shifting inequity to equity. This process involves representation from diverse stakeholders, appropriate resource allocation to community initiatives, continuous communication, shared decision making, and ownership with community members[22, 23].

Refer to the Community Coalition Assessment Tool to begin forming meaningful collaborations and assess partnerships on an on-going basis[24].

STRATEGY 1: Identify Appropriate Partners

ACTIVITIES

1. Identify stakeholders in the local geographic area that are addressing population health needs. (see Activity #4 and Reflective Exercise #5(a) and 5(b))
    a) Reach out and connect with relevant stakeholders from the community and other organizations to learn about current initiatives to address population health needs[5] (e.g., local municipal government, poverty groups, seniors, youth, addiction and mental health). (see Reflective Exercise #1 and Activity #4)
    b) Determine which single-agency initiatives would benefit from partnerships with additional agencies[25] (e.g., justice, social workers, police services, faith-based organizations). (see Reflective Exercise #3)
    c) Considering the population target, use a grassroots approach to identify and engage with the appropriate teams to benefit the population[19]. (see Reflective Exercise #1)
2. Determine with community partners which providers/organizations will assess and deliver care for the specific needs of the target population[19.] (see Reflective Exercise #10 and 13)

Note: Understanding and assessing community services in your local region can be a primary goal. This will enable you to create groups of relevant community organizations and establish community context to determine who you might want to have a voice in planning.

STRATEGY 2: Create a Shared Vision

ACTIVITIES

1. Learn and discover your shared values with the community to improve resilience (e.g., prioritization exercises to understand population and community health needs). (see Reflective Exercise #3, and 6)
2. Prioritize community needs together with community agencies and individuals with lived experience to determine which population health needs to focus on. (see Reflective Exercise #6, 7, and 9(a) and (b))
3. Create a common vision of community wellness and population health needs with the community centred around addressing health inequities through an effective joint service planning approach. (see Reflective Exercise #8, 9, and 10)
4. Identify what each organization can contribute and what mutual benefits (e.g., resources that can be shared such as listing services, technology, evaluation) may arise from working together[25]. (see Reflective Exercise #3, 4(b), 12 and, 13)

STRATEGY 3: Establish Mutual Goals to Ensure Understanding

ACTIVITIES

1. Create a common understanding with the organizations you work with for comprehending and defining the population health needs of the community. (see Reflective Exercise #5 and 6 and Activity #1, 2, 3, and 4)
2. Learn about relevant and appropriate qualitative and quantitative information acquired from your community partners and/or individuals with lived experience. Information sources could include community engagement, community epidemiology and social determinants of health trends, health equity analysis of health needs, healthcare utilization data, and patient stories. (see Reflective Exercise #4(a) and (b), and Activity #1, 2, 3, and 4)
3. Use the relevant information and experiences of your community partners to identify and prioritize community health needs. (see Reflective Exercise #4(b))
4. Validate your priority needs by returning to your community with data and stories. Does your information match their experiences? (see Reflective Exercise #7)
5. Determine which organizations and agencies can provide the best information/input to assess and address the mutually identified priority population health needs. (see Reflective Exercise #3, 4(b), 5(a) and (b))
6. Use data (qualitative and quantitative) to inform organizational strategic direction and the programs and services related to population health needs[26].
    a) Common measures should be feasible, sustainable to collect and assess, and translatable to the local government level.

STRATEGY 4: Resource Mutually Reinforcing Activities to Improve Community Resilience

ACTIVITIES

1. Work with community partners to identify key steps, resource allocation, and strategies to overcome barriers to participation (e.g., affordable public transportation and/or childcare, skill development to assist in engaging in social interaction) needed to engage community residents.
2. Come to a mutual understanding of what community resilience would mean for the health and well-being of the community (e.g., capacity, structures). (see Reflective Exercise #8, and 10)
3. Develop and/or support tools that enhance community resilience across settings and services at the community level[5]. (see Reflective Exercise #8 and 9(a) and (b), 10)
4. Share and learn of current initiatives and planning strategies with community partners to identify gaps and opportunities to improve care with community and inter-sectoral partners based on population needs. (see Reflective Exercise #3, and 5(a) and (b)).
5. Co-create a plan of action supported by leadership to coordinate activities amongst community and other inter-sectoral partners that address population health needs (e.g., business plan and service plan) and emphasize the voice of agencies and community members in your collaboration. (see Reflective Exercise #8, and 10)
    a) Continuously revisit group priorities and objectives. Where has there been success and where are areas for improvement? Use this opportunity to reevaluate strategies and connect partners that can share resources to meet shared objectives.
6. Determine measures or metrics of success.

STRATEGY 5: Support Continuous Communication and Engagement with Partners

ACTIVITIES

1. Hold frequent and structured open communication (online if in-person is not possible) with partners to build trust, assure mutual objectives, and create common motivation. Arrange a regular team meeting and discuss each professional's role, scope, and expertise. (see Reflective Exercise #12, 13)
2. Facilitate on-going meetings with the public as an opportunity to engage with partners and community members. These will provide opportunities for discussion and feedback and allow interested community members to develop agenda items, give presentations, and set goals for the group[25].
    a) Distribute relevant and appropriate communication materials to partners to ensure they are aware of upcoming opportunities and individual progress.
3. Promote innovation in communication by co-creating partnership agreements[27] and establishing role agreements within and between organizations (e.g., accountability agreements, care pathways and protocols). (see Reflective Exercise #11 and 13)
4. Build and sustain relationships to: improve the social fabric amongst local health services, community partners, municipal government, workplaces and community members; assess capacity; and mobilize/utilize community assets and resources to address and support local population health needs[5]. (see Activity #4 and Reflective Exercise #4(b), 5(a) and (b), 12, and, 13)
    a) Determine any additional resources and supports team members require to effectively assess and address the needs of the community and populations they serve[19]. (see Reflective Exercise #1, 3 and 9(a) and (b), 10, 13)

STRATEGY 6: Determine a Backbone Organization to Guide Vision and Strategy

ACTIVITIES

1. Select a decision-making structure (non-hierarchical) within the round-table with a clear understanding of who will guide the vision and strategy of the partnership. (see Reflective Exercise #12, 13)
2. Facilitate dialogue between leadership, partners, providers, and individuals with lived experience to advance the strategy and build trust amongst partners[33].
3. Facilitate and coordinate the resources (e.g., fiscal agency) and supports needed (e.g., time for leadership and administrative support, on-going communication/email, applying for government and grant opportunities, fundraising, recruiting volunteers, and other non-monetary supports) to sustain cross-sector partnerships[28]. This includes a convener, network coordinator, communicators, facilitator, provocateurs, leavers to promote bridging, design teams, and implementation teams[29]. **(see Reflective Exercise #13)**

ENABLER

Continuity and Service Coordination

The conditions and ongoing relationships needed to support seamless interactions and system navigation amongst multiple providers within interdisciplinary teams and/or across care settings and/or sectors (i.e., touch points)[18] to ensure patients/service users are supported where they live, work, and play (even where these may differ)[5]. Domains of continuity include interpersonal, longitudinal, management, and informational[30].

Refer to the Alberta Health Services Home to Hospital to Home Transitions Guideline as a tool for promoting care continuity and service coordination for patients in Alberta[31].

STRATEGY 1: Strengthen the Relationship with Providers and Provider Relationships

ACTIVITIES

1. Map assets and conduct needs assessments with partners and teams to consider which changes align with organizational strengths, priorities, and existing resources. (see Activity #4 and Reflective Exercise #4(a) and (b))
2. Leverage and coordinate resources within existing partnerships.
3. Develop a single point of access to allow providers to give service users warm handovers and follow-through to ensure service user needs have been met from the perspective of the user.
4. Develop opportunities and processes to connect providers and teams at the community level and encourage teamwork across settings and services[18].
5. Establish clear roles and responsibilities for service users (and their community supports) as full partners in their own care[5]. (see Reflective Exercise #12, and 13)

STRATEGY 2: Provide Comprehensive Care

ACTIVITIES

1. Care providers work with local care professionals, teams, and organizations to link service users with individuals with knowledge of local community resources to create a physical or virtual single point of access and ensure that ‘every door is the right door’. This will enable individuals to better navigate and access the health, social, and community supports they need to be as healthy and well as they desire[18].
2. Partner with community agencies and individuals with lived experience to understand which services are important to them and build resilience within the community to be healthy and well. (see Reflective Exercise #1, 3 and Activities #1, 2, 3, and 4)
3. Support and participate in local inter-professional care teams to provide a broad range of services.
    a) Team members have efficient communication within a physical or virtual network. This ensures that patients are always seen by a professional with relevant skills who is able to connect them with an appropriate care team to address their individual needs[13].
4. Coordinated services are efficiently delivered between healthcare and medical services (e.g., PCN, AHS programs), as well as services provided by the government, education, justice, social, and community-based organizations, where deemed appropriate, to avoid duplication of services and promote sustained cross-sector integration[18].

STRATEGY 3: Develop Appropriate Technology Supports

ACTIVITIES

1. Create and support the development of virtual networks (e.g., web-based portals or platforms) that connect service users and providers across different sectors (e.g., health, education, housing) to deliver services and supports that address local population health needs[5,18].
2. Co-develop and sustain with service organizations an infrastructure (e.g., data collection templates) that supports access to an accurate and sustainable inventory of services (e.g., health, education, housing) that is up to date, user friendly, and integrated[5].
    a) Co-develop a third party platform where groups with lived experience, community agencies and health organizations can place their contact information and share their experiences (e.g., careopinion.org). Ideally, this platform would be accessible through a mobile app that would allow anyone to access this information at any time.
3. Co-create terms of reference for information exchange between organizations and care providers. This will ensure privacy, methods of data sharing, and information and record keeping are understood and aligned in consideration with Alberta's Health Information Act.
4. Support population health registry building, tracking and reporting of population health needs indicators and outcomes[5].

References

1. National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE implementation and action toolkit: protocol for responding to and assessing patients' assets, risks, and experiences. Bethesda (MD): NHCAC; 2019 Mar. 126 p. Available from: http://www.nachc.org/research-and-data/prapare/toolkit/
2. Short SE, Mollborn S. Social determinants and health behaviors: conceptual frames and empirical advances. Curr Opin Psychol. 2015 Oct;5:78-84.
3. Canadian Institute for Health Information. A performance measurement framework for the Canadian health system. Ottawa (ON): CIHI; 2013. 42 p. Available from: https://secure.cihi.ca/free_products/HSP_Framework_Technical_Report_EN.pdf
4. National Treatment Strategy Working Group. A systems approach to substance use in Canada: recommendations for a national treatment strategy. Ottawa (ON): Canadian Centre on Substance Use and Addiction; 2008 Oct. 46 p.
5. Alberta Health Services. A vision for chronic condition and disease prevention and management. Edmonton (AB): AHS; 2016 Sept. 22p.
6. Institute of Medicine. Healthy, resilient, and sustainable communities after disasters: strategies, opportunities, and planning for recovery. Washington (DC): National Academies Press; 2015.
7. Canadia Public Health Association. Policy and position statements: Climate change and human health [Internet]. Ottawa (ON): CPHA; 2019 [cited 2020 May 5]. Available from: https://www.cpha.ca/climate-change-and-human-health
8. Jameton A, Pierce J. Environment and health: 8. Sustainable healthcare and emerging ethical responsibilities. CMAJ. 2001 Feb;164(3):365-9.
9. Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, Mc Lean R, et al. Stigma in health facilities: why it matters and how we can change it. BMC Medicine, 2019 Feb;17(1):25.
10. Public Health Agency of Canada. Addressing stigma: towards a more inclusive health system. Ottawa (ON): PHAC; 2019 Dec. 78 p.
11. Dover DC, Belon AP. The health equity measurement framework: a comprehensive model to measure social inequities in health. Int J Equity Health. 2019 Dec;18(1):36.
12. Magis K. Community resilience: an indicator of social sustainability. Soc Nat Resourc. 2010 Apr;23(5):401-16.
13. College of Family Physicians of Canada. A new vision for Canada: family practice - the patient's medical home. Mississauga (ON): CFPC; 2019. 35 p.
14. Government of Canada. Social determinants of health and health inequalities [Internet]. Toronto (ON): Government of Canada; 2019 [cited 2020 May 5]. Available from: https://www.canada.ca/en/public-health/services/health-promotion/poggpulation-health/what-determines-health.html
15. Buy Social Canada. A guide to social procurement. Vancouver (BC): Buy Social Canada; 2018. 84 p. Available from https://www.buysocialcanada.com
16. World Health Organization. Health systems: governance [Internet]. Geneva: WHO. 2020; n.d. [cited 2020 May 5] Available from: https://www.who.int/healthsystems/topics/stewardship/en/
17. McKesson Canada. Patient-centered care: a framework for care coordination. Saint-Laurent (QC): McKesson Canada; 2013. 6 p.
18. World Health Organization. Continuity and coordination of care: practice brief to support implementation of the WHO Framework on integrated people-centred health services. Geneva: World Health Organization; 2018. 69 p.
19. Alberta Health Services. A primer on the population health needs-based approach. Edmonton (AB): AHS; 2006.
20. Alberta Health Services. A healthier future together: the 2017-2020 health business plan. Edmonton (AB): AHS; 2017. 33 p.
21. Community Places. Community planning toolkit: community engagement. Belfast (UK); 2014. 24 p. Available from: https://www.communityplanningtoolkit.org/
22. Tamarack Institute. The collaboration spectrum tool. Waterloo (ON): Tamarack Institute; 2017. 2 p. Available from: http://www.tamarackcommunity.ca/library/collaboration-spectrum-tool
23. Kania J, Kramer M. Collective Impact. Stanford (CA): Stanford Social Innovation Review; 2011. 41 p. Available from: https://ssir.org/articles/entry/collective_impact#
24. Alberta Health Services. Improving integrated healthcare through community coalitions in Alberta. Edmonton (AB): AHS; 2019. 61 p.

25. Rudolph L, Caplan J, Ben-Moshe K, Dillon L. (2013). Health in all policies: a guide for state and local governments. Washington (DC) and Oakland (CA): American Public Health Association and Public Health Institute; 2013. Available from: https://www.apha.org/topics-and-issues/health-in-all-policies

26. Government of Ontario Ministry of Health and Long-Term Care. Protecting and promoting the health of Ontarians. Ontario public health standards: requirements for programs, services, and accountability. Toronto (ON): Government of Ontario; 2018. 74 p.

27. Government of British Columbia Communications and Public Engagement. The service design playbook. Victoria (BC): Government of British Columbia; 2014. 131 p.

28. Collective Impact Forum. What is Collective Impact [Internet]. 2014. Available from: https://www.collectiveimpactforum.org/what-collective-impact

29. Collaborative Leaders Network. What is a Convener? 2020; Available from: https://collaborativeleadersnetwork.org/leaders/the-role-of-the-convenor/

30. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. BMJ. 2003 Nov;327(7425):1219-21.

31. Alberta Health Services Primary Healthcare Integration Network. Alberta's home to hospital to home transitions guideline: keeping Albertans and their circle of care connected. Edmonton (AB): PHCIN; 2020. p. 36.