Population Health Needs Framework User's Guide

How to begin understanding the needs of your community

Alberta Health Services

ALBERTA MEDICAL ASSOCIATION | ACTT Accelerating Change Transformation Team

Primary Care Networks

Acknowledgements

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The content within this User's Guide is based on experiences and lessons learned from thought leaders, early adopters, and champions of service planning across Canada, with a focus on health service planning within Alberta. We thank all of these individuals for sharing their experiences, successes, and areas of improvement with us so that others may advance in their own journey to address population health needs when planning for care.

Although this framework is directed towards addressing the health needs of all Albertans, it is important to acknowledge the historical and inter-generational trauma of the Indigenous people of Canada. Unjust racism, colonization, and residential school policies continue to perpetuate unjust health barriers and delivery of fragmented health services for Indigenous people[1]. As an organization, AHS is committed to honouring the recommendations set out from the Truth and Reconciliation Commission of Canada: Calls to Action[2], and continues to support reconciliation, self-determination of health priorities, and improving health outcomes and healthcare experiences for the Indigenous peoples of Alberta[1]. We honour and respect the knowledge, and expertise of the traditional Knowledge Keepers and Elders within Indigenous culture and understand the importance of delivering care and services that are offered in a culturally safe environment[3]. The wide scope of this document may not directly address the distinct needs of Indigenous peoples, but may provide high-level guidance towards holistic, co-design initiatives that work towards reducing the health inequities between Indigenous and non-Indigenous people[1].

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 this 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 peer-reviewed literature (150 articles), grey literature, 49 key informant interviews, and a Modified Delphi process were used to identify essential elements of population health needs. From this process, six domains of population health needs were identified: broad determinants proven to influence health. The Population Health Needs Framework for Service Planning has been structured around these six domains.

To further support users of the Framework, this accompanying User Guide was created. This 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.

Pages 3-4 of the Framework were created to guide stakeholders and partners as a standalone document during service planning. Use these 2 pages to begin a conversation on activities that might be helpful to identify community and population health needs.

How to Use This User's Guide

This User's Guide contains suggested exercises and tools that may be helpful during service planning conversations between healthcare service organizations, community services, social services, not-for-profits, voluntary organizations, municipalities, and/or government planners planning for population health needs in Alberta. *Pick and choose amongst these activities* to begin identifying what matters most to individuals, communities, or populations living within defined geographic areas. This User's Guide is considered an 'evergreen document' and as such, we expect this document to be adapted and updated based on your experiences and feedback. If you have any questions or concerns about this document please contact **Alberta Health Services - phc@ahs.ca.**

The Process

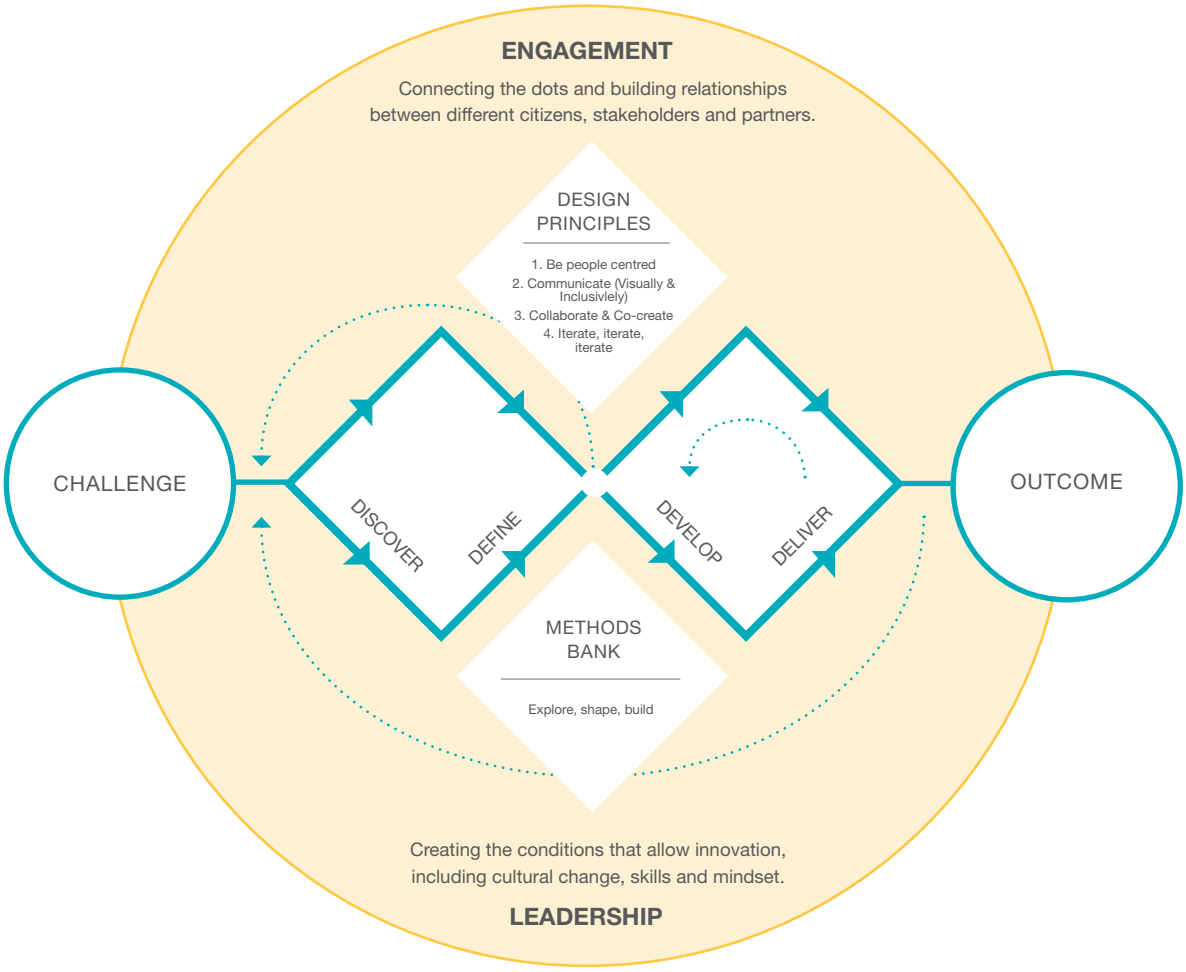


Image adapted from Design Council's Framework for Innovation[5]

DISCOVER

The first diamond helps individuals understand, rather than simply assume, what the problem is. It involves speaking to and spending time with people who are affected by the issues.

DEFINE

The insight gathered from the discovery phase can help you to define the challenge in a different way.

DEVELOP

The second diamond encourages people to give different answers to the clearly defined problem, seeking inspiration from elsewhere and co-designing with a range of different individuals.

Legend

DOMAINS

Physical, Biological & Mental Health

Social Environment

Natural Environment

Community Adaptiveness & Resilience

Built Environment

Socioeconomic and Political Context

ENABLERS

Appropriate Governance & Structures

Continuity & Service Coordination

Collective Impact & Intentionally Collaborating to Co-Create

LEVEL OF IMPACT

Population

Community

Zone or Provincial

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)

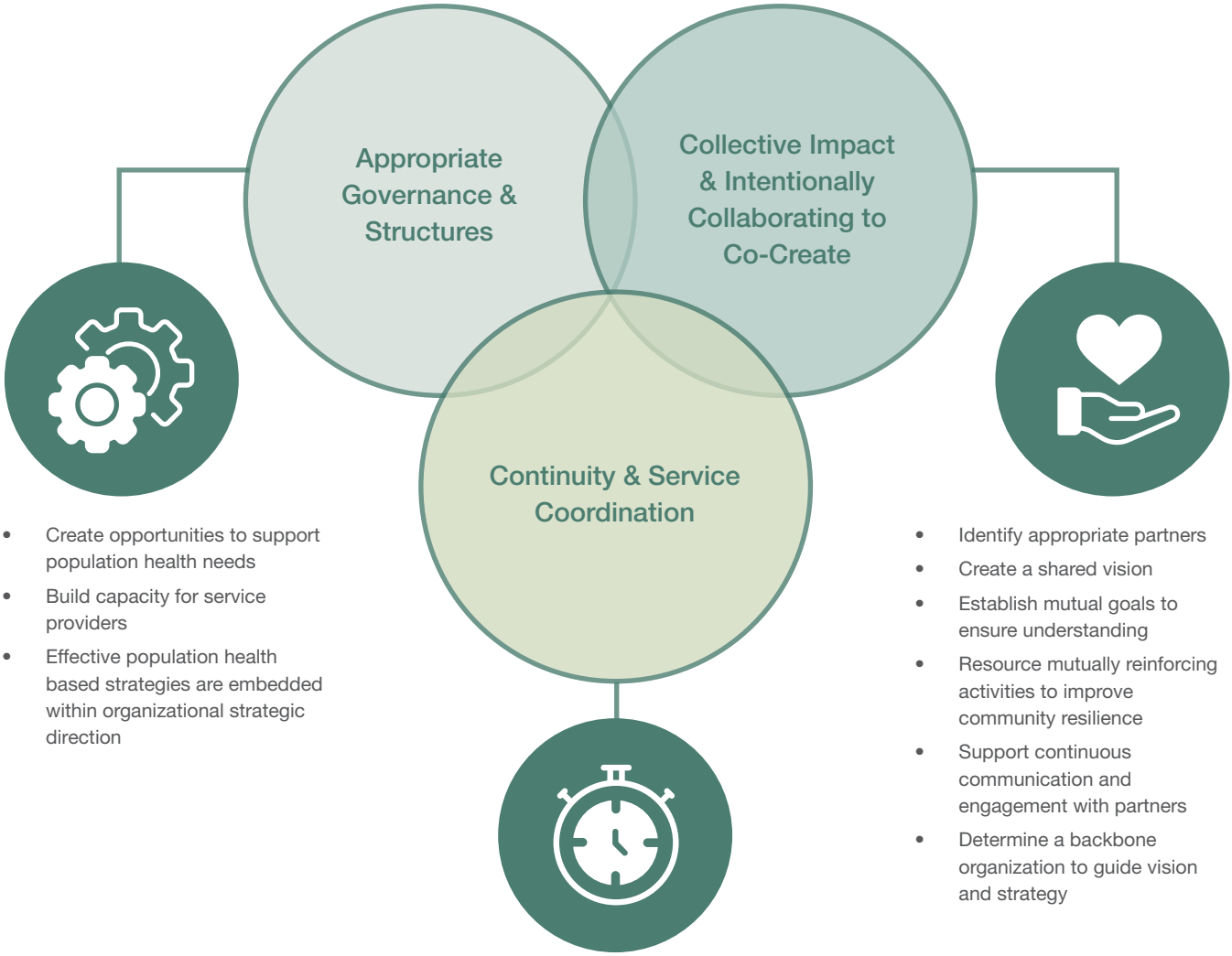
Socioeconomic and Political Context

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

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

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 feasible in a few years, 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 useful to begin planning and addressing population health needs.



- 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

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Who should you invite to the table?

Reflective Exercise #1:
Who do you see co-designing services together in your community?

1. Brainstorm with service providers in your geographical area. Use the image below as an example of potential service providers and those with lived experience who might work together to address health needs.
    - Aim to have fewer than 25 attendees to ensure everyone's voice is heard.
2. Reserve a meeting room at a location that is conducive to social innovation and located within the community setting to set the scene for design thinking.
    - Not everyone may be able to attend in-person. Consider incorporating online platforms (e.g., Zoom, Google Meet, join.me, Skype) in the innovation space.

Your group may include but is not limited to:

Other Resources:

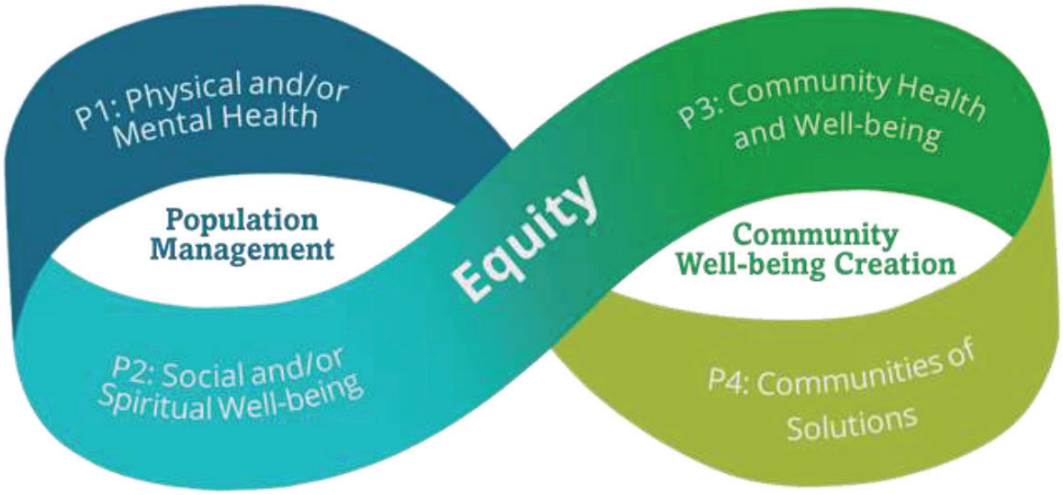
Primary Healthcare Opioid Response Initiative. Year 2 Summary Evaluation Report – Meaningful engagement of individuals with lived experience. March 25, 2020.

How do you understand where you are at?

Mental models are how we assess system processes and they help us make better decisions. Which mental models do potential community partners use to address health needs? Here are some tools and exercises to explore how providers and users see the world. They can be used to start a conversation with community service partners.

Reflective Exercise #2:
To be used with community service providers and users

1. In which portfolio (P1/P2/P3/P4) does your organization currently focus most of its efforts?
2. Which portfolio do you see the most opportunity for your organization to address population health needs?



Institute of Healthcare Improvement: Pathways to Population Health Framework[7]

Reflective Exercise #3

Use the Team Canvas template to understand each community partner organization's purpose, people, roles, values, goals, rules and action points of service partners. This activity could be guided by a group facilitator.

1. Ask each community partner to fill in the Team Canvas based on their organization.
2. The facilitator will combine these responses and reflect with the whole group.

The Team Canvas Basic

Most important things to talk about in the team to make sure your work as a group is productive, happy and stress-free

TEAM NAME: _____ **DATE:** _____

PEOPLE & ROLES

What are our names and the roles we have in the team?

VALUES

What do we stand for? What are guiding principles? What are our common values that we want to be at the core of our team?

PURPOSE

Why are we doing what we are doing in the first place?

GOALS

What we want to achieve as a group? What are our key goals that are feasible, measurable and time-bound?

RULES & ACTION POINTS

What are the rules we want to introduce after doing this session? How do we communicate and keep everyone up to date? How do we make decisions? How do we execute and evaluate what we do?

Source: The Team Canvas[8]

What types of information do you need?

Reflective Exercise #4

A) Gather Data to Understand Needs

1. This activity could be completed by a student or intern. This activity should be completed prior to meeting with potential service partners.

2. Gather diverse sources of data — both qualitative and quantitative.[9]

A population health approach relies on diverse data sources, including: census records, vital events registries, regulatory or quasi-regulatory systems, and patient stories and experiences. Suggested data types include: environmental data, lifestyle data, vital statistics data, social and economic data, epidemiological data, health systems data, consumer information, demographics.[9] For additional examples refer to the image within Reflective Exercise #4b.

Additional Resources for Healthcare Data:

- Alberta Health Interactive Data Dashboard: http://www.ahw.gov.ab.ca/IHDA_Retrieval/
- Healthier Together Community Health Dashboard: https://www.healthiertogether.ca/prevention-data/alberta-community-health-dashboard/
- AHS Zone Service Planning Map: https://bit.ly/2HAa25P
- HQCA Focus on Healthcare: https://focus.hqca.ca/
- CIHI Your Health System: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/
- AHS Tableau Dashboard: https://public.tableau.com/profile/alberta.health.services#!/

B) What Types of Information do you Have to Understand Needs?

The purpose of this activity is to understand the different types of data and information available to you. This information might be from stories (qualitative) or from existing reports (quantitative). It might be publicly available (external) or require agreements between partners (internal). Use this grid with potential service partners to gather different types of information on health needs.

1. Which quadrant contains the largest amount of information on health needs?
2. Are there types of information missing that would be useful during a service encounter?
3. Do potential service partners have the ability to share information that is usually available internally? (e.g., summary information rather than private clinical data)

*Individual patient advisors may not be interested in attending this event; however, there may be patient advisory groups that would be interested in weighing in.

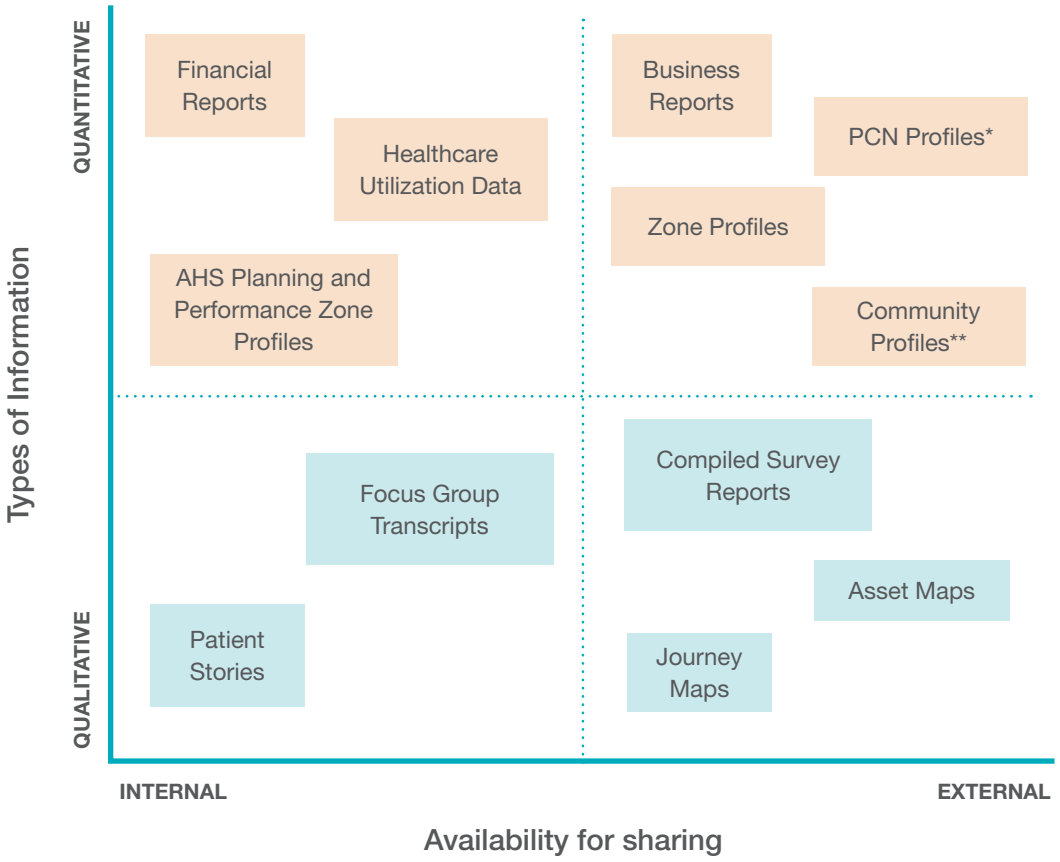


Image Adapted from The Periodic Table of Product Periodization[10]

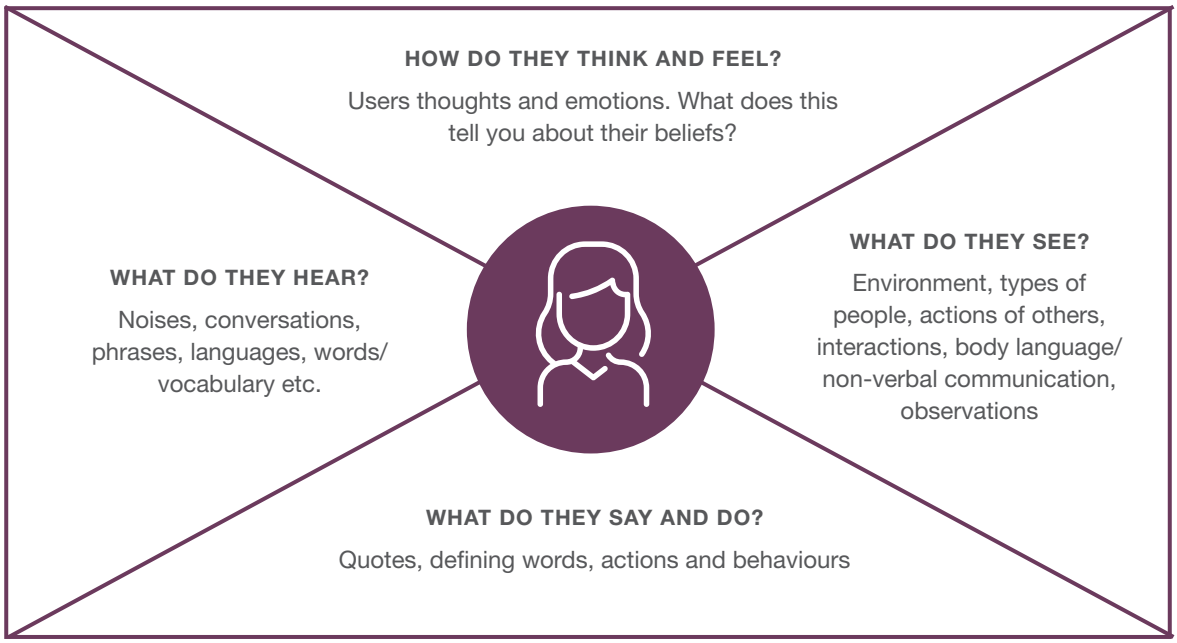
*PCN Profiles[11]

**Community Profiles[12]

How do you bring the lived experience into a conversation about services?

Activity #1: Empathy Mapping

Empathy mapping is a simple tool to understand and reflect on lived experiences. Empathy mapping can be completed by selected patients or through information gathered from interviews and/or observations. This map will be created with a group rather than one-on-one with an individual, emphasizing that the map is a "snapshot" of experiences. It is not meant to represent the only journey, but serves as a high-level, bird's eye view of a collection of experiences.



Use this image to walk in the shoes of a patient or population who uses services to address health needs. What are their thoughts and feelings about services? What do they see when accessing and using services (the environments they face and the types of interactions they have)? What have they heard about these services? What words come to mind when thinking of these services? What are barriers and opportunities when accessing and using these services?

- **Tips on creating a safe space:** https://thefuselight.com/patient-journey-mapping-tips-for-creating-a-safe-space/
- **Additional Resources:** The AHS Co-Design Playbook (https://s3-us-west-2.amazonaws.com/transformativelearning/2019/test/Integrated+Care+Partnerships+Guide+DRAFT+1.1.6.9.pdf)

Activity #2: Community Personas

Community personas are a way to combine information and insights collected from community service providers and service users. Personas will be created with a group rather than one-on-one with an individual, emphasizing that the persona is a “snapshot” of experiences.

Ideally, community service providers would create several personas which reflect populations accessing services. Of these, 3-4 personas might reflect accessing an ‘average’ level of services and 3-4 personas might reflect accessing an ‘extreme’ level of of services. Creating personas helps planners by providing a picture of the population needing services and an understanding of how providers conceptualize health needs.

1. Use the image below as a template to create a persona of a typical service user. Each persona from this exercise would lend itself to creating 6-8 journey maps in the next exercise – including a variety of populations, ‘normal’ and ‘extreme’ users.
2. Validate the personas with actual service users (e.g., patients) to see if your understanding is reflective of actual experiences.

Persona Template

<table>
<tr><td rowspan="2">  </td><td>Interests</td><td>Powers</td></tr>
<tr><td rowspan="3">Quote:

Name:

Age:

Profession

Bio:</td><td>Goals</td><td>Daily Routine</td></tr>
<tr><td>Fears and Worries</td><td>Motivation</td></tr>
</table>

Note: Look at both the 'average' and 'extreme' user in the local context. This can provide novel insights into the population of interest

Interests

- Cooking
- Reading
- Going for walks outside with her friends from the neighbourhood

Powers

- Is connected with other mothers in her neighbourhood
- Has University education from India
- Has her driver's license
- Is fluent in Hindi and English

Quote:

"How will I support my children when I can't even take care of my own health?"

Name: Eralia

Age: 45 years

Profession: Part-time Teacher

Bio:

- Recently moved to Canada from India
- Single parent
- Three children (ages 21, 16 and 10 years old)
- Low income with no health benefits
- Recently diagnosed with Type 2 Diabetes

Goals

- To provide a good future for her children
- To get proper treatment and medication for her diabetes
- To get accustomed to Canadian values
- To visit her family in India

Daily Routine

- Is on call for daily substitute teaching positions
- Prepares meals for her children and sends the younger two off to school
- Cleans the house
- Goes for a walk with her friends

Fears and Worries

- Having to depend on an inconsistent job for financial needs
- Cannot afford to visit her family
- Not being in control of her health

Motivation

- To help her children adjust to Canadian culture
- Have enough income to support her children
- Manage her diabetes to stay healthy for her children

Example: Eralia's Persona

- **Tips on creating a safe space:** https://thefuselight.com/patient-journey-mapping-tips-for-creating-a-safe-space/
- **Additional Resources:** The AHS Co-Design Playbook (https://s3-us-west-2.amazonaws.com/transformativelearning/2019/test/Integrated+Care+Partnerships+Guide+DRAFT+1.1.6.9.pdf)

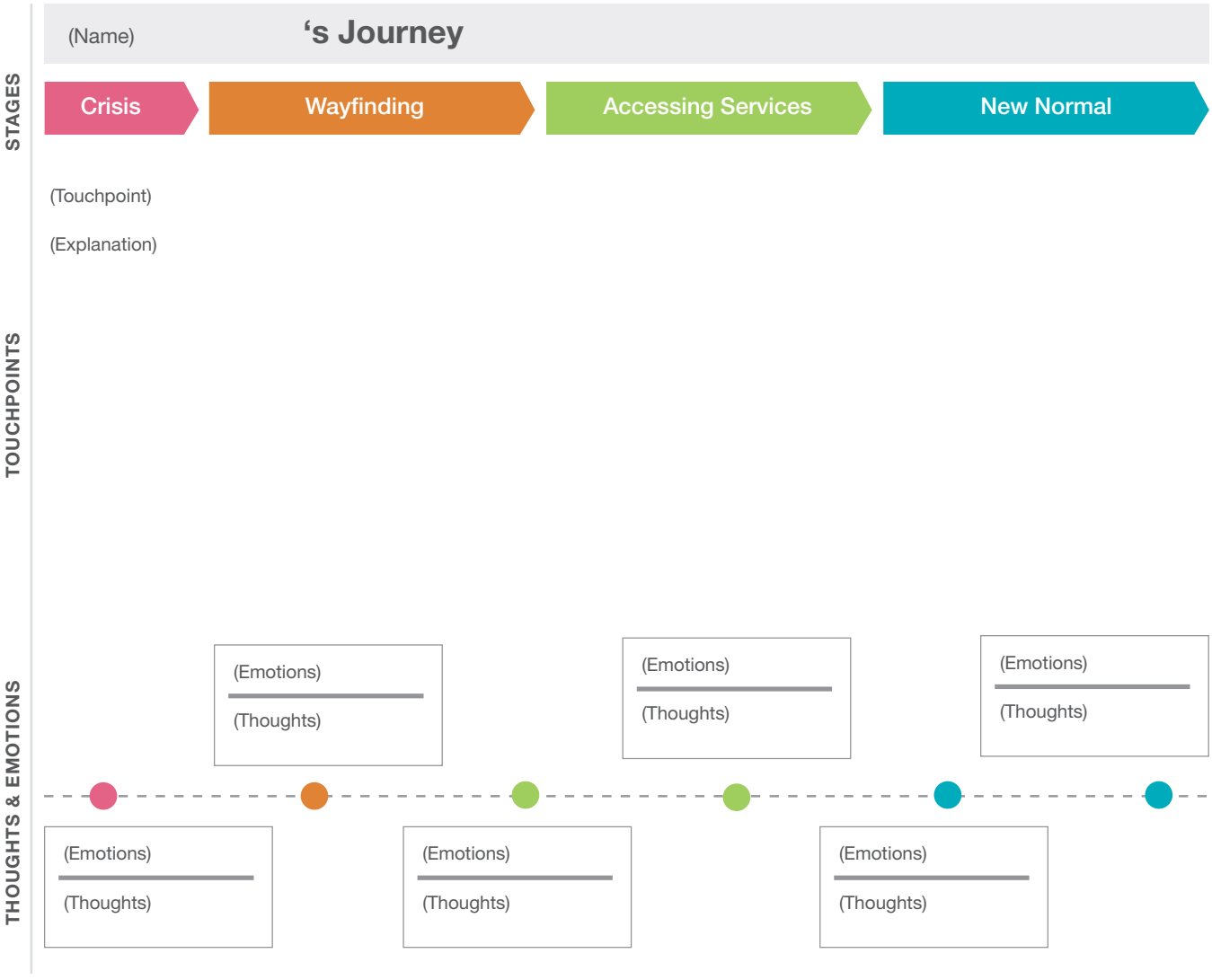
Activity #3: Journey Mapping

Journey mapping is another exercise that can be used to create a reflection of the collective experiences of select patients or specific populations. It can be used to identify particular emotions (positive and negative) that affect individuals when navigating services. These journeys highlight needs that a service provision currently addresses and could potentially improve when planners address population health needs. This map is created with a group rather than one-on-one with an individual, emphasizing that the map is a "snapshot" of experiences. It is not meant to represent the only journey, but serves as a high-level, bird's eye view of a collection of experiences.

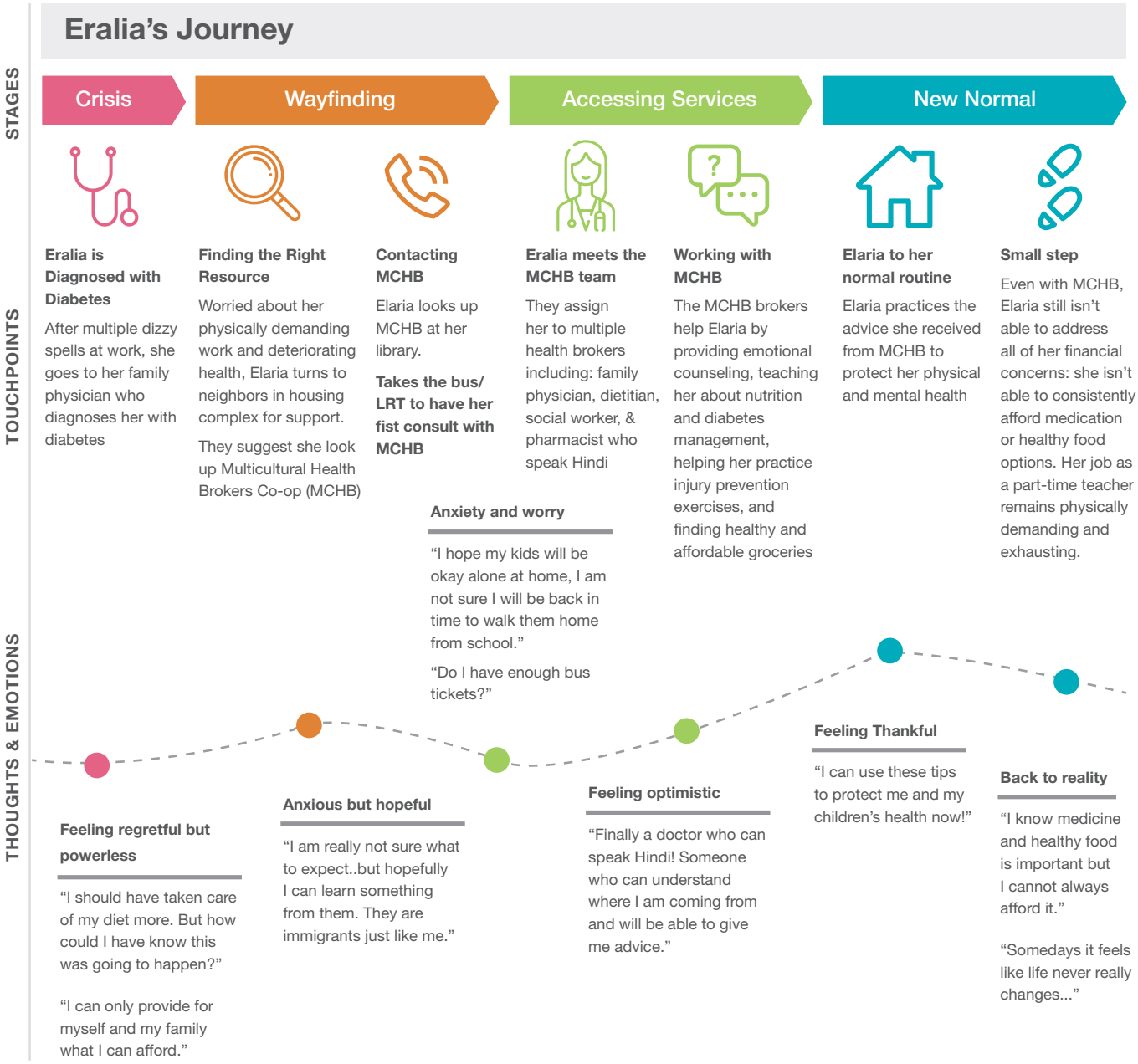
1. Use the image below as a template to create a journey of a typical service user. Each persona from the previous exercise would lend itself to creating 6-8 journey maps – including a variety of populations, 'normal' and 'extreme' users.

2. Validate these journeys with actual service users (e.g., patients) to ensure that these reflect actual experiences.

Journey Mapping Template



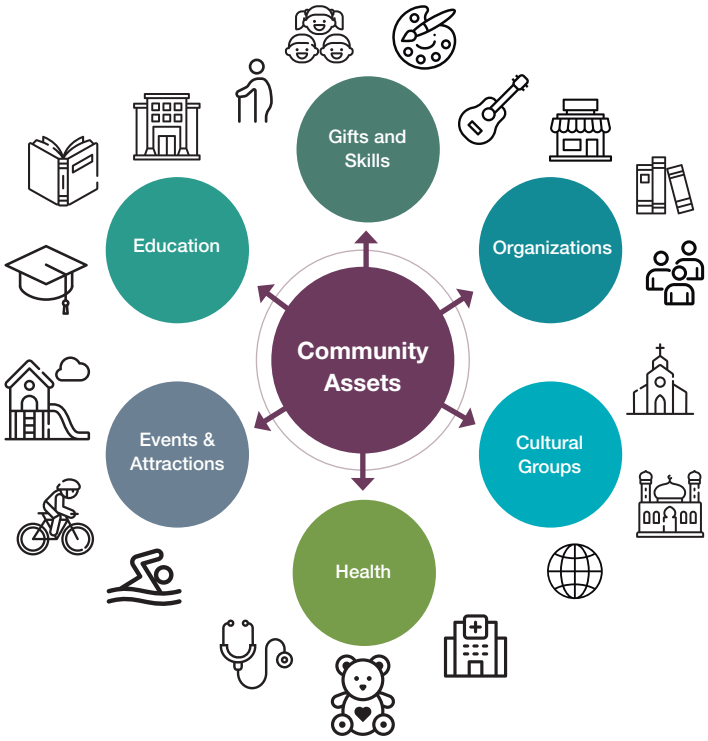
Example: Eralia's Journey Map:



- **Tips on creating a safe space:** https://thefuselight.com/patient-journey-mapping-tips-for-creating-a-safe-space/
- **Additional Resources:** The AHS Co-Design Playbook (https://s3-us-west-2.amazonaws.com/transformativelearning/2019/test/Integrated+Care+Partnerships+Guide+DRAFT+1.1.6.9.pdf)

Activity #4: Asset Mapping

A community asset (or community resource) is anything that can be used to improve the quality of community life[13]. An asset map is a visual tool that highlights persons, physical structures, places, community services, resources, connections, and 'gifts' in and around a geographical community. Asset maps enable service planners to identify community resources, the relationships between people and/or organizations, and individual assets.



Healthier Together: Alberta Healthy Communities Hub[14]

1. This is a great project for students and interns.
2. Start with what you know. Take an inventory of all the groups (associations, organizations, and institutions) that exist in your community.
3. It might be fun to ask others in your community to join in and validate the asset map.

Questions for the potential service partners to consider[15]:

1. What do you think a "perspective of abundance" means? Can you think of an example?
2. Why would viewing a community from a perspective of abundance (as opposed to a perspective of deprivation) help improve health?
3. Have you ever done a community needs assessment? What was it for? How did it help your work?
4. What did you learn? Did anything surprise you?

Additional Resource:

- Identifying community assets and resources (https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main)

Reflective Exercise #5: Assessment of Population Health Needs

(5a). Current Assessment Tool

1. This exercise can be completed by a student or intern.
2. See domains (Appendix 2) and essential enablers (Appendix 1) for ideas and examples of population health needs and system level enablers.
3. Use your information sources from **Reflective Exercise #4, and Activity #1, 2, 3, 4**.
4. Using the different types of information, use the following table to take an inventory of health needs affecting your community.
5. It might be beneficial to add rows to the table to document specific health needs.
6. Who else might want to validate this table? i.e., ask your community members.

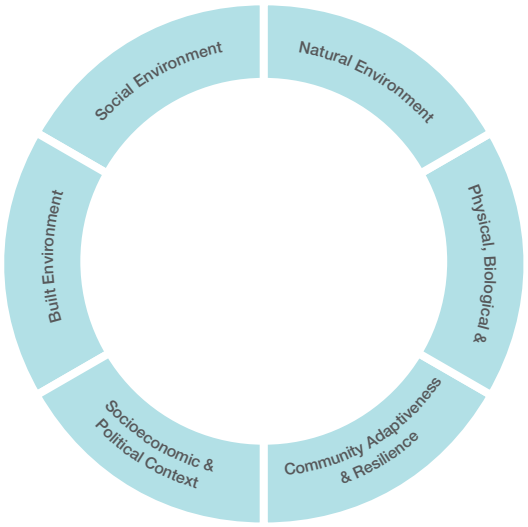
Population Health Need	Positive Effect	Negative Effect	No Effect
Physical, Biological, & Mental Health	☐	☐	☐
Built Environment	☐	☐	☐
Social Environment	☐	☐	☐
Natural Environment	☐	☐	☐
Community Adaptiveness & Resilience	☐	☐	☐
Socioeconomic & Political Context	☐	☐	☐

Adapted from the Health Impact Assessment Guidance[16]

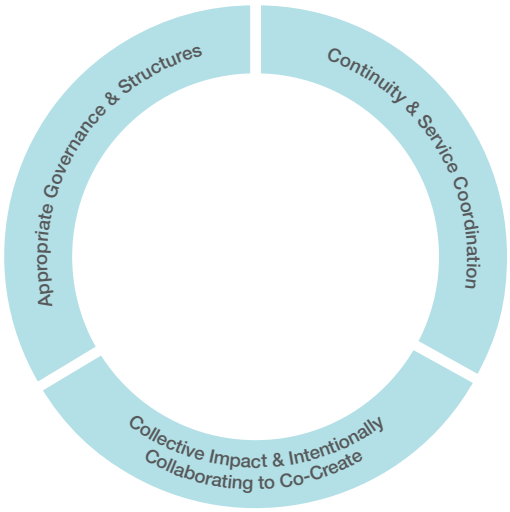
(5b). Current Assessment Wheel

1. This activity can be completed by each individual who participates in the co-design service planning process.
2. Use these wheel templates (domains and enablers of population health needs) to identify your areas of strength, where you might improve, and where you might do better.
3. Draw a line under relevant domains or enablers with the corresponding colour (green, yellow, red) to represent your community's area of strength or improvement. After you have finished your layer, pass the circle to the next person at the table. Each line represents individual service partners.
4. Use a consensus process to create a single wheel for all stakeholders.
5. Reflecting on the group picture, which domains or enablers are primarily red or missing? How can these be addressed?

TEMPLATE: HEALTH NEEDS DOMAINS



TEMPLATE: HEALTH NEEDS ENABLERS



EXAMPLE OF A COMPLETED DOMAIN WHEEL

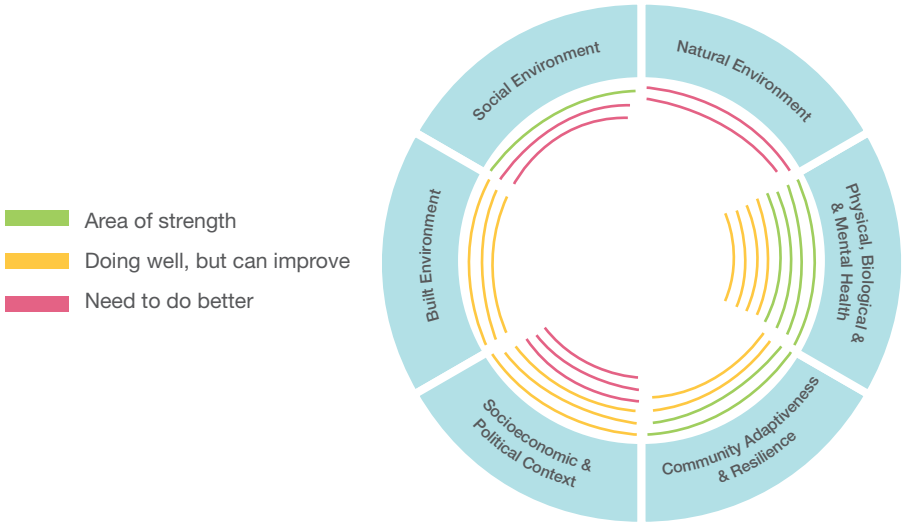


Image and Activity Adapted from the Rotterdam Resilience Strategy[17]

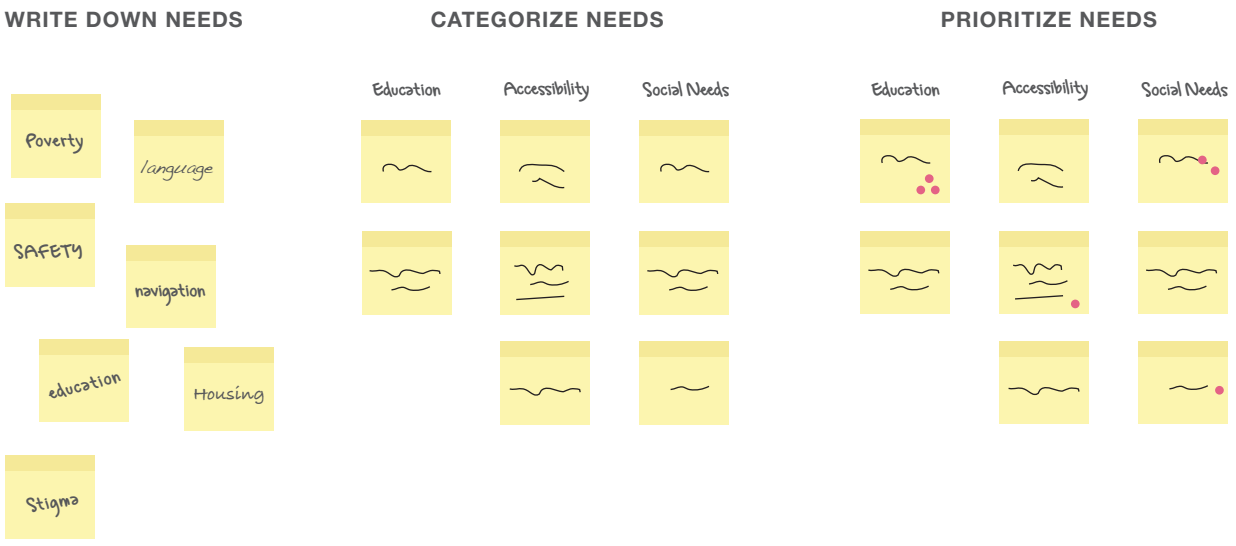
How might you understand your community's needs?

Reflective Exercise #6: How might we prioritize needs together for communities?

1. This activity can be completed with your stakeholders, including community service organizations and patients and families.
2. Use your information sources from **Reflective Exercise #4, and Activity #1, 2, 3, 4**.
3. Take 5 minutes when you meet with your community partners to write (or draw) needs you observed in your community. Use one sticky note for each need.
4. Group together sticky notes based on common themes or categories.
5. Give three sticky dots to each community service partner. Ask each partner to use a colored dot to identify priority needs. Which needs are chosen most amongst the group?

Note: Needs may expand beyond the population level to system level enablers (e.g., communication, navigation, funding).

See domains (Appendix 2) and essential enablers (Appendix 1) for ideas and examples of population health needs and system level enablers.



Reflective Exercise #7

1. Based on information gathered and priority needs, are there populations accessing services that are not represented based on these needs?

   a. Service partners will need to re-visit who is not represented within the stakeholder list. How might we bring in the lived experience for these sub-populations?

2. Validate health needs with potential service partners.

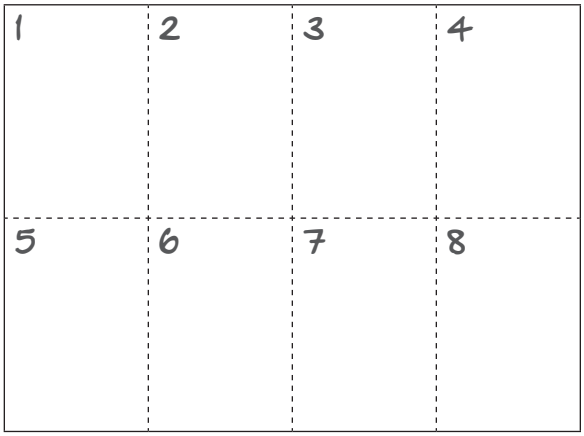
   a. How do you see the community's health needs overlaying with the population health needs domains and enablers? Do all of your needs fit into one domain? Are any health needs missing?

- **Additional Priortization Resource:** https://ctb.ku.edu/en/developing-strategic-and-action-plans

Reflective Exercise #8: Crazy 8's Core Method to Generate Solutions

This is an exercise to complete with your community service partners.

1. Each partner will draw a grid with 8 empty boxes and fold the sheet into eight sections.
2. Set the timer for 8-minutes and ask everyone to sketch eight ideas or solutions.
3. Are their similar solutions? What are some unique ideas?
4. Each partner will choose one solution to further explore.
5. What information will be needed for this idea or solution?[9]
6. Which ideas or solutions will fit both the priority need and the current context?[9]
7. How long will this idea or solution take to implement?[9]
8. Choose up to 4 solutions to further explore in **Reflective Exercise #9 and 10**.



Source: Method taken from Google Design Sprint Tool Kit[18]

Reflective Exercise #9: To begin prioritizing solutions

1. Complete this activity in small groups with your community partners
2. Service partners will fill in this template with their selected idea or solution from Reflective Exercise #8.
3. **Change Proposal:** Describe your proposal or plan for change including the goals and vision of your solution.
4. **Identify Forces for Change:** Identify internal and external factors that drive change (e.g., declining team morale, outdated technology, changing demographic trends). Consider the benefits this solution will deliver, who supports this change, what resources do you need to make the change work?
5. **Identify Forces Against Change:** Identify internal and external factors that are unfavourable to change (e.g,. government legislation, existing organizational structures, lack of funding).
6. **Assign Scores:** Rank each force (For and Against change) from 1 to 5 according to the degree of influence that each force has on the solution (1 = weaker influence, 5 = greater influence). Sum the scores for each side (For and Against).

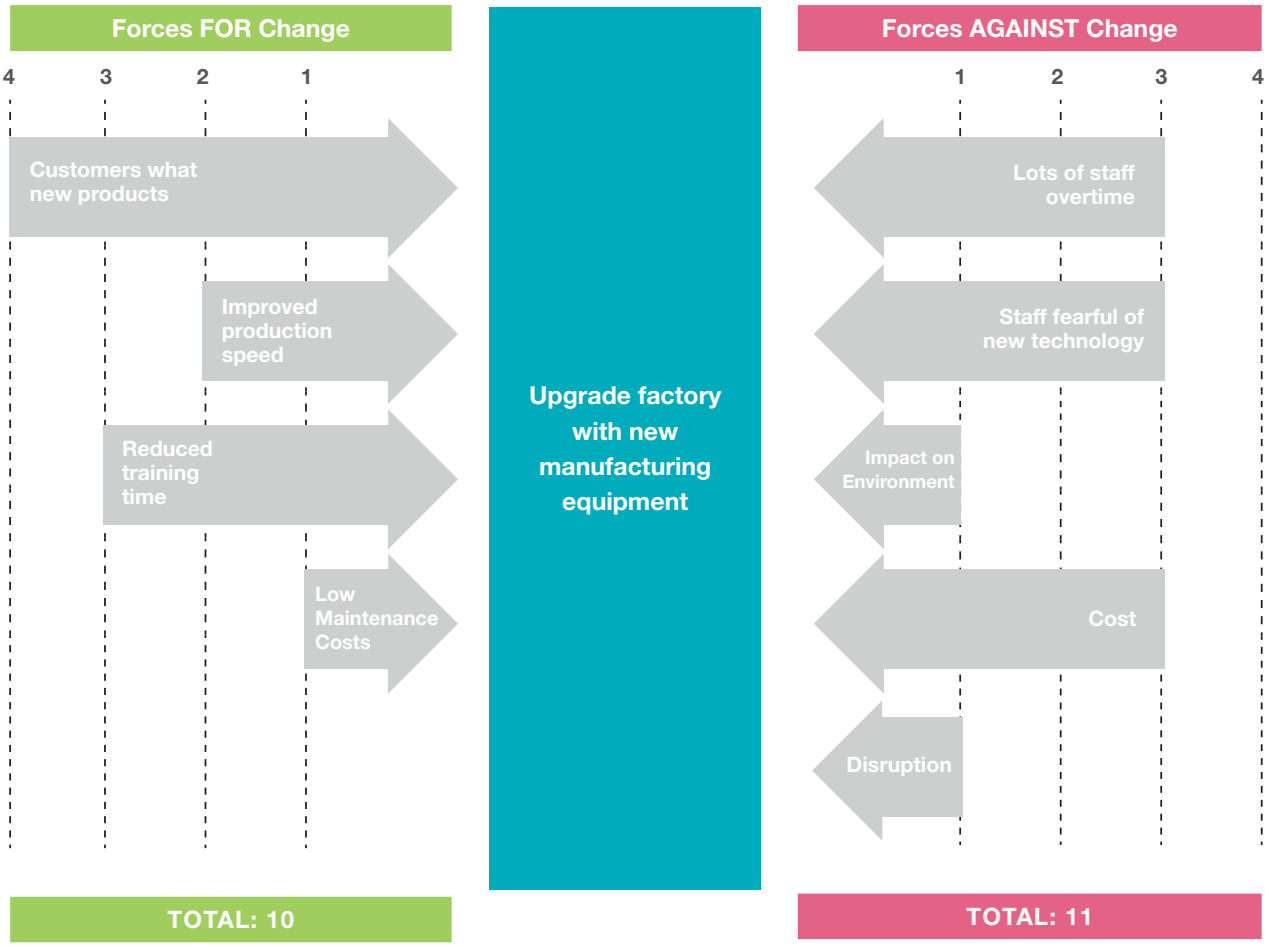
Forces FOR Change	Score
TOTAL	

Change Proposal

Forces AGAINST Change	Score
TOTAL	

Adapted from Force Field Analysis[19]
(https://www.mindtools.com/pages/article/newTED_06.htm)

7. Create a visual representation of the influence of each force on the proposed solution. Draw arrows around each influence and size according to the assigned rank. Bigger arrows will have a greater influence on change and smaller arrows represent forces with a weaker influence.



Adapted from Force Field Analysis[19]

(https://www.mindtools.com/pages/article/newTED_06.htm)

Reflective Exercise #10: Storyboarding

1. This activity is completed with service partners after choosing an idea or solution.
2. Complete this activity in small groups.
3. **The Challenge:** Identify the priority needs to be addressed (write or draw).
4. **The Big Idea:** How might we address the priority need (write or draw)?
5. Set the timer for 15 minutes to fill in this template.
6. Share the storyboard with the larger group for feedback.

The Challenge

The Big Idea

Who is this for?

What age? Socio-economic status? Interests?

Why this group?

What factors make this group need this product/system/service/experience?

How will you do it?

Key partnerships? Community volunteers?

What are your next steps?

How could you expand on this prototype?

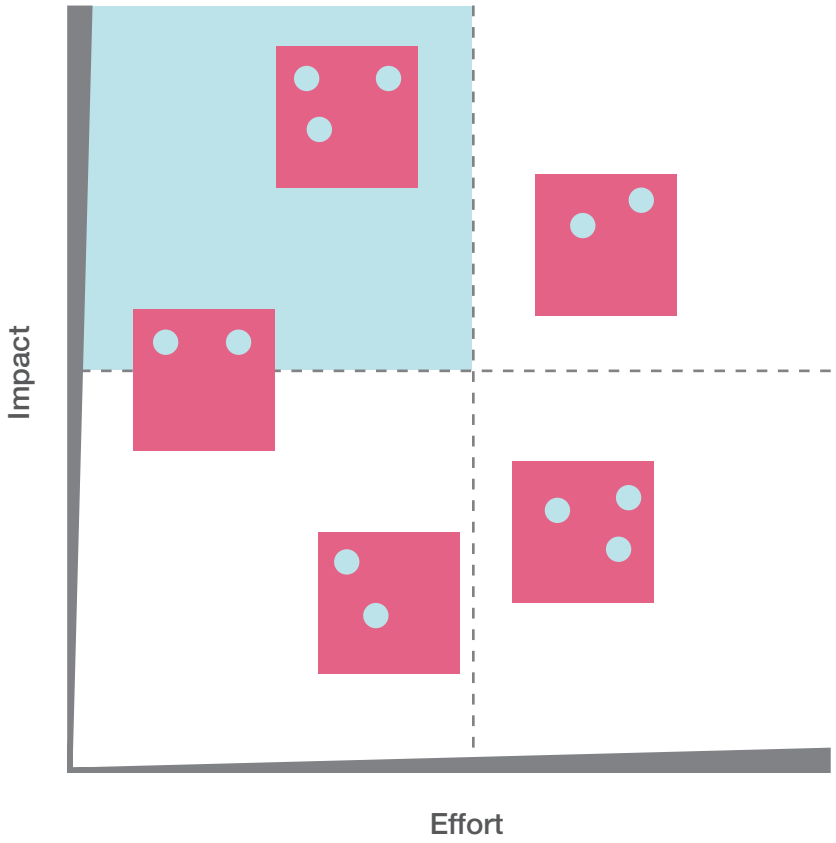
What else is there to consider?

Are there possible challenges that don't have a solution yet?

Reflective Exercise #11

1. This activity is best completed with community partners.
2. Complete this template after service partners decide on 3 or 4 solutions.
3. Use this grid to understand the feasibility of your group's ideas to address health needs based on the required effort (complexity) and impact (value to end user).
4. Organize your solutions on this grid.

It will become clear which ideas are low-hanging fruit and which ones are harder to implement but still valuable.

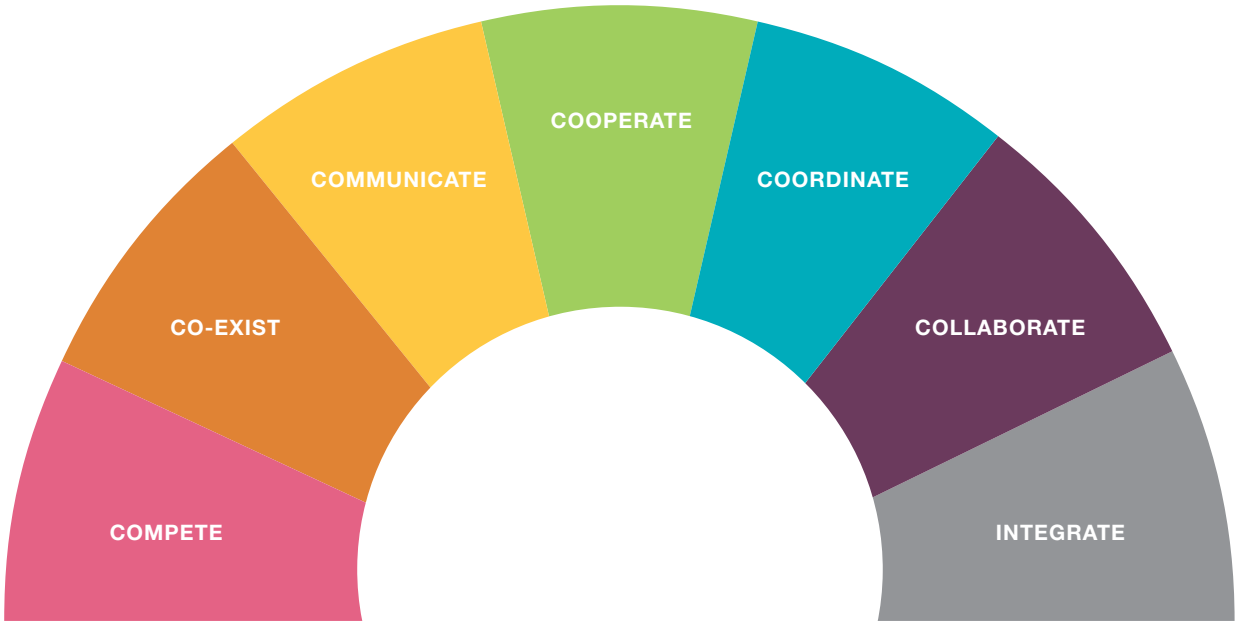


How do you start addressing population health needs?

Reflective Exercise #12: The Collaboration Spectrum

These are guiding questions[21] to reflect on collaboration with potential service partners.

1. How are you feeling about collaboration within your community?
2. What positive collaboration experiences have you had? What negative experiences have you had? What are your hunches about what contributed to the positive and negative experience?
3. What learnings do you want to take to future situations?
4. How might you apply your learnings to this collaboration?
5. How do the ways we worked together in the past impact how we work together today?
6. What does the group want to be mindful of when working together? What is important for the group to pay attention to?
7. What assumptions and beliefs might you hold going into this collaborative work?
8. What might success look/sound like to you?



Adapted from Tamarack Institute Collaboration Spectrum[22] and the AHS Indigenous Health Strategy[23]

Reflective Exercise #13: The Project Canvas

Use the Project Canvas template to understand the purpose, scope, success criteria, milestones, actions, team, stakeholders, users, resources, constraints, and risks of your team.

1. Ask service partners fill in sections of this template.

2. The facilitator will reflect with the group on responses.

Project name _____ Project owner _____

Purpose
What is the intent of this project?
Why are we doing this project?

Scope
What does this project contain?
What does this project not contain?

Success Criteria
What do we need to achieve in order for the project to be successful?
How can the Success Criteria be measured?

Milestones
When will we start the project and when is the final deadline ?
What are the key milestones and when will they occur?
How can the milestones be measured?

Actions
Which activities need to be executed in order to reach a certain milestone?

Outcome
What is the end result?
- A book
- A website
- An event

Team
Who are the team members?
What are their roles in the project?

Stakeholders
Who has an interest in the success of the project?
In what way are they involved in the project?

Users
Who will benefit from the outcome of the project?

Resources
What resources do we need in the project?
- Physical (office, building, server)
- Financial (money)
- Human (time, knowledge)

Constraints
What are the known limitations of the project?
- Physical (office, building, server)
- Financial (money)
- Human (time, knowledge, politics)

Risks
Which risks may occur during the project?
How do we treat these risks?

Image from Project Canvas[24] (http://www.projectcanvas.dk/)

Checklist for Planning Days

Note: Examples of supplies and may differ depending on your event

- ☐ Projector or smart board
- ☐ Laptop
- ☐ Name-tags (self-stick) for each person
- ☐ Large 25” x 30” Post-it Self-stick easel pad
- ☐ 3” x 3” coloured Post-Its for each person
- ☐ 200 feet Newsprint or craft paper roll
- ☐ Dry-Erase Markers and Dry-Eraser
- ☐ Black Sharpies
- ☐ No.2 pencils
- ☐ Ballpoint pens for each person
- ☐ Roll of masking tape or invisible tape
- ☐ Scissors
- ☐ End-of day reflection exercise

Glossary of Terms

Acceptability: Health services are respectful and responsive to user needs, preferences and expectations[25].

Accessibility: Health services are obtained in the most suitable setting, within a reasonable time and distance[25].

Appropriateness: Health services are relevant to user needs and are based on accepted or evidence-based practice[25].

Community: Group of individuals that interact with each other through defined geographic boundaries and/or any group sharing something in common, including a shared social fabric with common values, beliefs, behaviors, and/or interests[26].

Community Resilience: The existence, development, and engagement of community resources by community members to thrive in an environment characterized by change, uncertainty, and unpredictability[27].

Continuity of Care: How a patient experiences care over time as coherent and linked. It occurs when separate and discrete elements of care are connected[28].

Collaboration: Longer term interactions that are based on a mutual understanding, as well as shared goals, decision-making, and resources[22].

Collective Impact: A collaborative, inter-sectoral approach that addresses complex social problems by fostering a grassroots approach to community. This is supported by centralized resources, dedicated staff, and a structured process to reinforce a common agenda, shared measurement, continuous communication, and mutually reinforcing activities amongst all partners[29,30].

Effectiveness: Health services are based on scientific knowledge to achieve the desired outcomes[25].

Efficiency: Resources are optimally used in achieving desired outcomes[25].

Health Inequity: The avoidable inequalities between and within population groups that can positively or negatively influence health status, access to health services and other life opportunities. Many health inequities can be reduced by addressing population health needs in policies and program operations[31].

Life Course: The life experiences of an individual or a population that influence health and disease. The life course recognizes the influence of the past and present on the broader social, economic and cultural context[32].

Lived Experience: A representation of individual, community, and population experiences, choices, and options and the resultant effect of these on health and well-being[33].

Inclusion: An enhanced sense of belonging that is achieved by being included in a group or community structure.

Indigenous: The collective name for the descendants of the original inhabitants of North America. The Canadian Constitution recognizes the following three groups of Indigenous people: First Nations, Métis, and Inuit[34].

Shared Responsibility: There is a shared duty for care providers to enable and support desirable conditions to support population health needs.

Needs: Individually perceived or professionally evaluated necessities to achieve a desired state of well-being[35].

Primary Care Network (PCN): The most common model of team-based primary healthcare service delivery in Alberta. PCNs are groups of physicians that work together in teams alongside health professionals such as nurses, social workers, dieticians, pharmacists to meet the primary healthcare needs of people in their communities. In 2020 there are 41 PCNs in Alberta. Together they represent more than 3,800 doctors and 1,000 healthcare providers and serve close to 3.6 million Albertans[36].

Population Health: An approach to health that aims to improve the health of an entire population through measuring and addressing the overarching health needs of the population and identifying and reducing health inequities among population groups[37].

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.

Safety: Mitigate risks to avoid unintended or harmful results[25].

Social Determinants of Health: Components of wellness and living conditions that influence the ability of an individual or population to achieve a desired level of health. The government of Canada identifies the main determinants of health as: income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviors, access to health services, biology and genetic environment, gender, culture, and race/racism[38].

Social Fabric: The bonds between individuals, communities, and populations that helps to form a culturally rich and socially cohesive community[39].

Stigma: Negative attitudes or beliefs about a population due to their circumstance in life. Examples of stigma include: discrimination, labeling, and stereotyping[40].

Well-Being: Positive outcomes that are meaningful for an individual, population or society. These outcomes are reflective of positive perceptions of one's livelihood. Physical, mental, social, and spiritual dimensions are all fundamental components to well-being[41].

Wellness: The active process where individuals and populations become aware of, and make choices towards more positive life experiences[42].

Suggested Resources

1. **Alberta Health Services. A Vision for Chronic Condition and Disease Prevention and Management (2016).**
   Available from: https://www.albertahealthservices.ca/assets/info/hp/phc/if-hp-phc-ccdmp-strategy.pdf

   This visionary document is an excellent resource to understand the role and responsibilities of care providers working along the continuum of care. It includes primary, secondary, and tertiary prevention strategies at the community, and health system level. Many of the enablers in the current framework were derived from this visionary document.

2. **Alberta Health Services. Together4Health (2020).**
   Available from: https://together4health.albertahealthservices.ca/

   Together4Health is an online public platform that highlights current and future Alberta Health Services projects and allows for public feedback. This website specifically includes updates on the population health needs framework and other projects funded by the Reducing the Impact of Financial Strain grant.

3. **British Columbia Government Communication and Public Engagement. The Service Design Playbook beta version one.**
   Available from: https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/services-policies-for-government/service-experience-digital-delivery/service-design-playbook-beta.pdf

   Similar to the Co-Design Playbook, the British Columbia Service Design Playbook takes a comprehensive approach to human-centered service delivery. The service design model within this Playbook is an outstanding model to understand the different phases of service design and deliverables and outcomes at each stage. This Playbook was used to help guide the development of several enablers in the current framework.

4. **Horizon Health Network Department of Population Health Promotion & Chronic Disease Management. Broadening Our Focus: Identifying regional priorities from the needs of our communities (2017).**
   Available from: https://en.horizonnb.ca/home/media-centre/publications/broadening-our-focus.aspx

   This is a fantastic resource to learn how Community Health Needs Assessments led to the development of regional priorities in New Brunswick. Section 5.5 of this document is useful to understand how to begin creating action and financial plans around regional priorities to impact change and improve population health. This may be a useful document to understand how to prioritize needs from regional data and how to begin developing services and solutions to address these needs.

5. **Institute for Healthcare Improvement. Pathways to Population Health: An Invitation to Healthcare Change Agents (2017).**
   Available from: http://www.ihi.org/Topics/Population-Health/Documents/PathwaystoPopulationHealth_Framework.pdf

   This framework is a great resource to learn more about how to identify opportunities that support population health needs. A figure in this framework, 'Portfolios of Population Health Framework' is used as a central mental model for our framework. It represents portfolios addressing population health needs and equity.

6. **Integrated Care Evaluation. Rainbow Model for Integrated Care: The Triple Aim (2016).**
   Available from: https://www.integratedcareevaluation.org/rainbow-model-for-integrated-care/

   The Rainbow Model for Integrated Care centers on 'The Triple Aim' objectives for appropriate care to benefit patients: Lower Cost, Improve Health, and Improve Care. Herein this model highlights the role services, professionals, organizations, and systems to achieve these objectives as well as functional and normative enablers to help achieve these objectives. This model is a useful tool to understand general roles and responsibilities and learn more about enablers that support population health needs.

7. **National Treatment Strategy. A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy (2008)**
Available from: https://www.ccsa.ca/systems-approach-substance-use-canada-recommendations-national-treatment-strategy

This strategy document presents a tiered model for continuum of services to support the chronicity and complexity of risks and harms associated with substance use. The strategic areas of action informed enablers within the current population health needs framework for service planning.

8. **Tamarack Institute. Collaboration Spectrum Tool (2020).**
Available from: https://www.tamarackcommunity.ca/library/collaboration-spectrum-tool

The Tamarack Institute is a phenomenal online resource that houses a free Learning Centre to support community change makers. The Collaboration Spectrum Tool is one of the resources provided by the Tamarack Institute. It provides a comprehensive overview of the continuum of collaboration and includes tools and activities to build collaboration amongst and within teams. The Collaboration Spectrum Tool and other great resources from the Tamarak Institute have been used to develop activities in this User's Guide and enablers of the population health needs framework.

9. **Community Tool Box (2020).**
Available from: https://ctb.ku.edu/en

Similar to the Tamarack Institute, the Community Tool Box is a great online resource for teaching, training, and activity resources for community development. Many of the resources within this Tool Box were used to guide activities within this User's Guide and inform the essential enablers.

10. **Population Health Approach Organizing Framework (2013).**
Available from: https://cbpp-pcpe.phac-aspc.gc.ca/population-health-approach-organizing-framework/key-element-1-focus-health-populations/

This framework focuses on how to collect and analyze population health status data for planning, implementation and evaluation.

Case Studies

The following case studies were provided from Albertan organizations that address population health needs. We hope these case studies can increase awareness of the phenomenal work being done within the province and provide insight into how inter-agency partnerships can be used to address population health needs.

Case Study #1:	Primary Healthcare Integrated Geriatric Services Initiative: Connecting People and Community for Living Well
Lens:	Physical and/or Mental Health, Social and/or Spiritual Wellbeing, Community Health, and Well-Being, Communities of Solutions
Domains:	
Enablers:	
Partners:	Seniors Health Strategic Clinical Network (SCN), Alzheimer Society of Alberta and the Northwest Territories, partners from Primary Care Network's (PCNs) and associated communities in the following PCNs: Aspen, Big Country, Provost, Red Deer, Wolf Creek.
Funding:	Grant funded: Alberta Health Enhancing Lives Grant through Alberta Health Services Seniors Health SCN
Level of Impact:	
Contact Information:	For more information on the PHC IGSI work, please contact the Seniors Health SCN at seniorshealthscn@ahs.ca, or visit the PHC IGSI webpage.

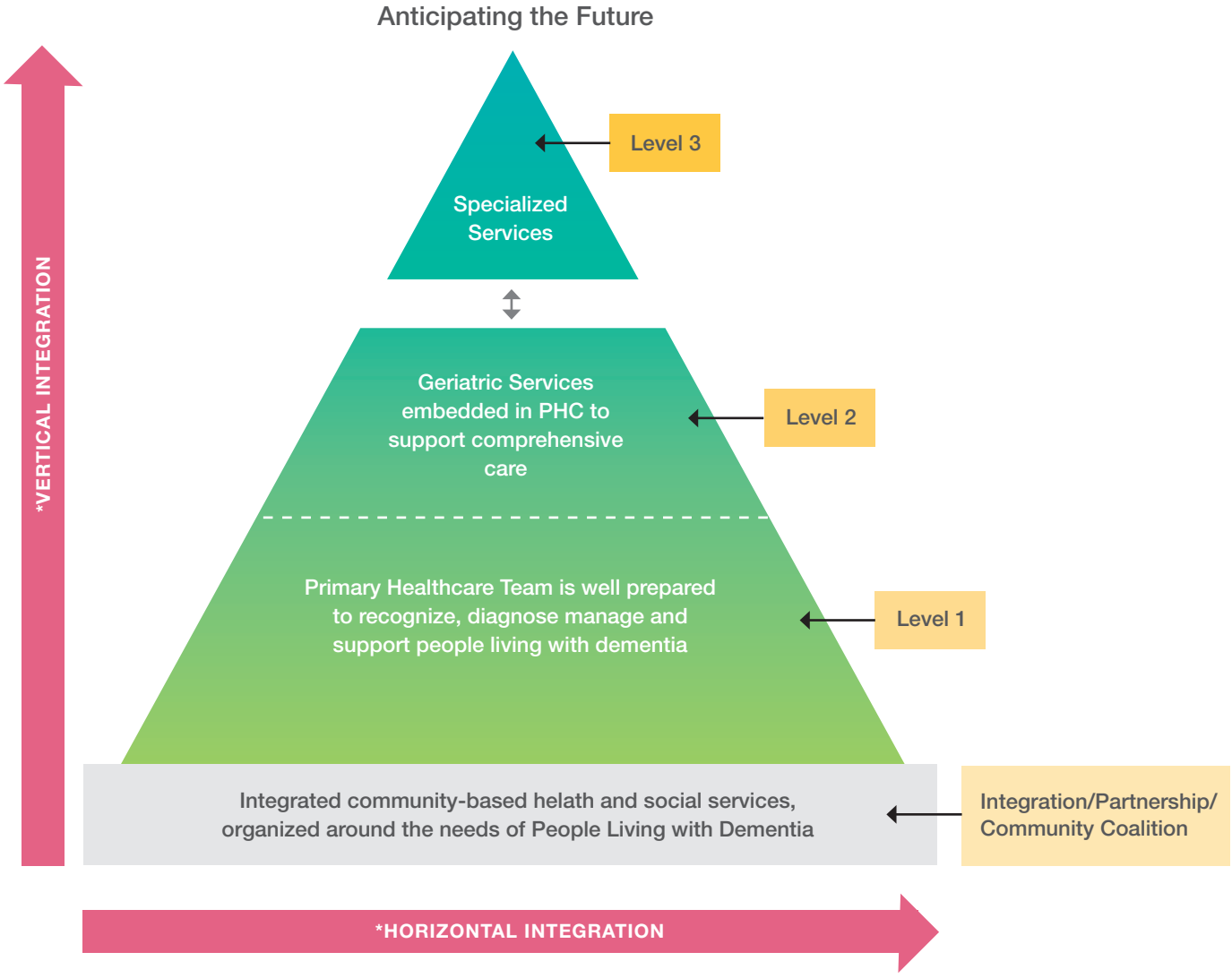
The demographics of the world's population is shifting. One example is that both the proportion, and absolute number of older people is rising (WHO, 2015). This creates an opportunity for nations to tap into the richness of knowledge and skills of older citizens, and to build health and social supports which support 'living well'. As older adults mostly live in their own homes as they age, there is opportunity for the sectors who support them to work together to enhance wellbeing. There are encouraging examples across the globe, and right here in Alberta of unique and innovative ways older adults are being supported.

In Alberta the population of those 65 and older will double by 2046. As dementia is also associated with increased age, the number of Albertans who will be diagnosed with dementia is expected to triple. To position the province to proactively support people affected by dementia, both those diagnosed and their carers, Alberta Health worked in collaboration with Alberta Health Services Seniors Health Strategic Clinical Network (SH SCN™) to develop a provincial strategy. The Alberta Dementia Strategy and Action Plan was released in December of 2018 and funded multiple priority initiatives. Prior to its release, Alberta Health recognized an opportunity to proactively fund a number of projects aimed at supporting achievement of the recommendations in the soon to be released provincial strategy. One such initiative was the Primary Healthcare Integrated Geriatric Services Initiative (PHC IGSI – pronounced FIG-SEE). This initiative started as a partnership between two Alberta Health Services (AHS) Strategic Clinical Networks (SCN™) – the Seniors Health SCN and the Primary Healthcare Integration Network, Primary Care Networks (PCNs), and the Alzheimer Society of Alberta and the Northwest Territories. The goal of the initiative is to enable primary healthcare teams to recognize, diagnose and provide ongoing care and support for those living in community affected by cognitive impairment, in order that they live well.

The provincial PHC IGSI project team meets every six weeks with the PCN clinical leads, and available community partners from each participating community to support action planning in order to achieve their local goals. The project team mentors, coaches, and raises awareness with teams as they plan for both vertical and horizontal integration activities at the local level.

In addition to offering support to the participating communities, the provincial PHC IGSI team has worked collaboratively to design and deliver four provincial educational workshops – each with 100 or more attendees representing the communities action planning, members of the public, and other interested groups from across the province. The workshops were designed to equip diverse teams to advance knowledge and skills to support individuals affected by cognitive impairment in all phases of dementia care. The team also hosts virtually a monthly Partner's meeting for participating teams, and any other interested parties from across the province where a variety of subject matter experts present, and teams have a chance to network and learn from each other.

The *Anticipating the Future framework* (see image below) guides the provincial PHC IGSI team and the participating communities to advance this goal. The vertical and horizontal stream activities work in tandem to support primary healthcare teams to increase their capacity to recognize, diagnose and provide ongoing care and support for those who live in community with dementia.



Vertical integration activities focus on increasing capacity within the healthcare sector to recognize, diagnose and provide clinical support for people experiencing cognitive changes. These activities bolster relationships and partnerships between healthcare sector partners (i.e. Primary Care, Home Care, Addiction and Mental Health) in order to support the wellbeing of the community dwelling aging population. Examples include: intentional connections with other partners in healthcare to understand roles, attending provincial and local education sessions to enhance clinical knowledge and skills, improved clinical processes which foster timely recognition and diagnosis, care planning from the 5Ms© approach, medication review processes, and timely connection to local resources for both the person with cognitive changes and their carers.

Horizontal Integration activities are those which occur across sectors. This includes actions and partnerships between the partners in the healthcare sector, social sector, and third sector as it is recognized that clinical care alone is not sufficient to address the challenges faced by older adults with dementia and their carers living in community. These activities focus on building partnerships between local health, social and community/municipal partners (i.e. Primary Care Networks, Home Care, Alzheimer's Society, local Town councils, etc.), as well as members of the public in order to plan for shared activities, and deliver services in order that individuals affected by dementia are supported well. Examples arethe development of a multi-sector community coalition, establishment of local programs/services which support the individual living with cognitive impairment and/or their carers, offering education and programming which supports multi-sector capacity building, and developing services from shared funding models within community.

Case Study #2:	How the Community of Drumheller is working together on “Connecting people for aging well”
Lens:	Social and/or Spiritual Wellbeing, Community Health
Domains:	
Enablers:	
Partners:	Town of Drumheller, Family and Community Support Services (FCSS), Drumheller and District Seniors Foundation, Big Country PCN, AHS Home Care, AHS Community Recreational Therapy, Alzheimer’s Society of Alberta and Northwest Territories, Volunteers from the community, Healthcare Aide (HCA) students from Healthy Campus Alberta, Local community groups
Funding:	No direct funding. Pooling of resources (financial and human) from health, social, municipal and third sector partners)
Status:	Completed a 10 week pilot program
Level of Impact:	
Contact Information:	For more information on the work in Drumheller, contact Amanda Panisiak at amanda.panisiak@bigcountrypcn.com. Refer to PHC IGSI Provincial Strategy for additional information on this provincial work

Drumheller is a rural community with a population of 6,439 people (Statistics Canada, 2016). Of those 6439 individuals, around 18% are 65 years old or older and just under 3% of those are 85 years of age or older. Drumheller is within the catchment area of the Big Country Primary Care Network (BC PCN). In 2016, the Big Country PCN and the community of Drumheller started participating in the Primary Healthcare Integrated Geriatric Services Initiative (PHC IGSI), a provincial strategy aimed at increasing capacity across primary healthcare teams to provide ongoing care and support for those living in the community with cognitive impairment or a diagnosis of dementia. Following attendance at PHC IGSI Learning Workshop #1 in June of 2016, the clinical lead for the work, a Registered Nurse in the PCN, endeavored to learn more about local services available to support seniors. She worked with local partners from health, social and community sectors to learn about each other’s roles, identify opportunities, and together establish priorities to work towards improving seniors supports in the community. To inform the local priorities, the newly created community coalition circulated a survey to elicit an understanding of the needs of the local seniors’ population. Coalition partners included members from the Town of Drumheller, Family and Community Support Services (FCSS), Drumheller and District Seniors Foundation, BC PCN, and staff from Alberta Health Services (AHS). The results of the survey identified several themes: transportation, meal program, and social programs for those with cognitive and physical limitations. The group held a meeting March 2019 where the priority and plans for a Community Day Program for those living with dementia began. The program was aimed at supporting those over 60 years of age living at home with cognitive impairment or a diagnosis of dementia. The program was held over a 10 week pilot cycle and provided 80 hours of respite for caregivers of four of eight participants. The Handi-bus fostered the ability to attend the program.

Evaluation of the Program Revealed:

PARTICIPANTS:

- 100% were happy/satisfied with the staff, setting and content of the program
- 100% expressed a desire to continue in the program
- Program created an opportunity to meet new people (for participants, and caregivers)
- Felt attending the program had a positive impact on their quality of life
- Participant feedback:
    - "I did not realize I was becoming a hermit at home, this program got me out of the house."
    - "This is the only time I get off the couch where I usually sleep all day."

CAREGIVERS:

- Identified that the program provided them with a break
- 100% were able to attended the monthly support group while their family member attended the program
- Received education and simple toolkits to use at home
- Had a reduction in caregiver burden scores

ADDITIONAL IMPACTS IDENTIFIED:

- After being part of the program, HCA students found they had a better understanding of, and increased comfort in, working with people living with dementia.
- An unanticipated positive was that participants and family members could tour the lodge in a very casual way; making the setting less intimidating.
- The opportunity to use the Handi-bus increased confidence of one participant to use this resources again to gain access to the community and its resources.
- The attendees at the local Alzheimer support group doubles as a result of running it at the same time as the Day Program.

It was recognized that attending the Day Program was a new activity for those involved – as such there was a period of adjustment within their routines which warranted reminder calls to participants and families each week. A challenge in the organizational logistics was how to address filling in for absent staff (i.e. due to illness).

The pilot was successful in creating an opportunity for connections to those who are normally socially isolated and for decreasing the burden to the caregivers of those with dementia. The interest is high to continue the program, necessitating a waitlist for interested participants. In spite of these successes, the ability of partners to offer their continued support is unknown. The hope is for the program to receive operational funding to help sustain.

Additional PHC IGSI related activities underway in Drumheller include: attending PHC IGSI Learning Workshops (four in total), local education at both the primary care clinic level and within the community for healthcare providers and community partners, incorporating the Geriatric 5Ms© framework into the practice setting in primary care, and improving access to the Seniors Outreach Nurse.

The Drumheller Clinical Lead meets every six weeks with the Provincial PHC IGSI team. The Provincial teams' role is to support the Clinical Lead and partners from the community to advance local work focused on increasing capacity to better support older adults – in particular those with cognitive impairment and their carers. The local work and the overall provincial PHC IGSI strategy work in tandem. Learnings from the local approach in Drumheller are adding to the understanding of impact at a provincial level:

- Well-being of those impacted by the local work (e.g. those with cognitive impairment and their carers)
- Healthcare sector partners. For example - referrals/admissions to Home Care, unplanned emergency department visits, or acute care admissions)
- Social sector partners. For example - referrals to Family and Community Support Services programs and services, Alzheimer's Society programs and services)
- Community/Municipal partners. For example – impact on local transportation (i.e. Handi Bus)

Case Study #3:	Bent Arrow Traditional Healing Society
Lens:	Social and/or Spiritual Well-Being, and Community Health and Wellbeing
Domains:	
Enablers:	
Partners:	Edmonton Police Services, Edmonton Public Schools, The City of Edmonton, Alberta Health Services, Common Service Delivery, Ministry of Family and Children Services
Funding:	Government of Alberta Collaborative Service Delivery
Level of Impact:	
Contact Information:	Cheryl Whiskeyjack: CWhiskeyjack@bentarrow.ca

Bent Arrow has been serving the Indigenous community in Edmonton and Area since 1994. We are able to provide a range of services to our community where each program and service was developed based on needs identified from the people we serve. We have a vision where our community can experience and expect to be safe and accepted no matter where they choose to approach for support. In saying this, we've always been an agency that sees this work best done in partnership. While we want to provide services that are relevant to our community, we also don't want to be an island to the community we serve. We have long standing partnerships with agencies, organizations and institutions that also serve our community (e.g. Edmonton Police Service, Edmonton Public Schools, The City of Edmonton, Alberta Health Services - to name a few).

Our mission is to build on the strengths of Aboriginal children, youth, and their families to enable them to develop spiritually, emotionally, physically, and mentally so they can walk proudly in both Aboriginal and non-Aboriginal communities. We are strongly grounded in addressing cultural aspects of our communities. We have an indigenous governance model1 as well as an indigenous practice model and have worked hard to have our way of working with our community as a good and solid way to practice that results in good outcomes. Our struggle at times was having our "western" colleagues and funders seeing this methodology as valid, relevant and measurable. The key players involved in this work are our leadership. We support the indigenous worldview and practice in the organization. Our funders helped us financially to develop our practice model called *Practice as Ceremony* which draw parallels between an indigenous ceremony and our practice with families. The Truth and Reconciliation played a key role in creating momentum in looking at how are we serving the indigenous community. How can we implement the calls to action?

We've been serving this community for over 25 years now and know that incorporating culture and ceremony in our work has netted some positive outcomes. Funders are now at the place where they too see the value and impact of our practice model. That said, we live in a world of outcomes and data and this is decidedly a very "western" construct, so the challenge has been drawing meaningful parallels between the two. This requires patience and time. For instance, we do not have a tool to demonstrate that a specific "Indigenous practice or intervention" had "X" effect on "X" individual, but we do have a tool to measure where employees were at when they started regarding practicing from an indigenous worldview. Therefore, we have a way to look at impact over time and have found more kids remaining in parental and kinship care (maintain connection to relatives and community), a rise in high school completions, lower incidents of involvement with justice, and better outcomes with all the other social determinants of health.

Our practice model uses “story” to help our practitioners see themselves practicing from an indigenous worldview (this is universal) and it creates a different space for all interventions to take place. I cannot articulate it within the restrictions of this case study, but we use the Sun Dance Ceremony and all its elements to draw parallels to our work. For example, the “Sun Dancer” is highly regarded in our communities for the sacrifices they make for the good of others. In our current practice the Sun Dancer is our client. The ceremony has a Stick Man whose role is to support and motivate the sun dancer to get through the ceremony (the intervention or working relationship). In typical western practice the client has a problem and the practitioner helps to resolve it. In our practice the aim is to follow along in the journey of the sun dancer and support them to complete the ceremony (which is very difficult).

Our training in the model takes a half day and we support staff daily to stay in the space to practice as if they are in ceremony. It is very powerful. Although it was created to support our work in child welfare, the model easily translates to our work in employment, housing, education, work with police, and virtually any system that touches our community.

Attached is a photo of the mnemonic device we use to share the teaching through story to our staff and community partners. It is a beaded illustration created by Tara Kappo (Driftpile FN) of a Sundance Ceremony. It depicts the arbor where the sun dancers are, the tipi’s represent community (in every service user story the community is different), the stickman, center pole, and it is on a turtle’s back (which indigenous people refer to as North America). Every element has a role, a story and a function. I am restricted by the parameters of the case study to explain each one.

http://www.fngovernance.org/resources_docs/Guiding_Philosophy__Governance_Model__Bent_Arrow1.pdf

Case Study #4:	Drive Happiness Seniors Assisted Transportation
Lens:	Physical and/or Mental Health, Social and/or Spiritual Well-Being, and Community Health and Wellbeing
Domains:	
Enablers:	
Partners:	Sage Seniors Association, Catholic Social Services, Westend Seniors Activity Centre, Edmonton Southside PCN, Living Sounds, Edmonton West PCN, Greater Edmonton Foundation Seniors Housing, Volunteer Strathcona, FCSS (Strathcona County, Stony Plain, Beaumont, Leduc County, Redwater, Morinville, Gibbons, Thorsby, Drayton Valley, and Devon)
Funding:	City of Edmonton, AGLC, Government of Alberta – Ministry of Seniors and Housing, Edmonton Community Foundation, Alberta Health Services – Community Innovation Grant for People Affected by Dementia, FCSS – Drayton Valley and Strathcona County
Level of Impact:	
Contact Information:	Liza Bouchard: liza@drivehappiness.ca

Drive Happiness Seniors Association is a registered, non-profit society whose mission is to assist seniors in remaining independent in their own homes for as long as possible. By providing seniors with mobility, we can help them ensure an independent lifestyle. We have been in operation since 1998, using volunteer drivers to get seniors where they need to be. Without access to transportation seniors are often at risk of becoming socially isolate due to lack of social interaction and participation in their communities.

Assisted transportation is a need for seniors. By providing access to affordable door-through-door transportation, seniors are able to get to medical appointments, social activities, and day to day errands, which helps fight social isolation and prevent unnecessary emergency healthcare. Assisted transportation is one piece of the puzzle for successful senior's care, but it is often the last piece to fit. Without a plan in place, seniors suffer in silence while overall costs and barriers result in:

- Increased ambulance trips
- Longer hospital stays
- More long-term care beds needed
- Higher levels of senior's abuse, social isolation and caregiver burnout

Many healthcare professionals look to address the social determinants of health when assessing seniors. One issue that we see time and time again is the afterthought of transportation, often causing seniors to miss appointments or pay for costly taxis. Having an accessible option – not only for seniors that are signed up, but also for healthcare professionals to use to book their clients transportation to get to their appointments, can decrease strain on the healthcare system, and long term care facilities, while preventing some physical and mental health problems caused by social isolation.

Seniors are the fastest growing demographic in Canada. Since 2015, Drive Happiness has grown by over 400% going from providing just 3,800 rides to seniors in 2015 to providing over 18,500 rides in 2019. The majority of our rides are directly for medical appointments, with a high number indirectly related to medical care, including accessing groceries, fitness classes, and programming. To use the service seniors fill out an application form and pay an annual fee ranging from $30 to $325 based on their annual income. Then a senior purchases a ticket for $10, which is good for 90 minutes of travel or up to 40 kilometers, whichever hits first. They book rides by phoning in and providing the office staff with all of their booking information, which then gets put into our database system. Our network of volunteer drivers, who are screened and vetted, have access to this system and can pick and choose which rides work best for their schedule. We provide volunteers a small gas reimbursement based on the number of rides they complete.

Consistency is currently still a challenge. We are working to create a self-sustaining funding model where we charge for tickets and annual fees on a sliding scale based on a rider's income. We are also working on corporate contracts where they pay market rate to use our service to get individuals to their clinics/ programming.

The key opportunities and successes with Drive Happiness include:

- Lowering strain on the health system. If seniors do not attend regular appointments they will rely heavily on acute care. We also see seniors overstaying their time in hospital after surgery simply because they do not have a trusted source to take them home.
- Lowering strain on long-term care seniors housing – seniors often pre-maturely move into long term care facilities simply because they are unable to access transportation.
- Working with some medical clinics that will book the transportation to their clinics and pay the cost. That way they ensure seniors attend their appointments and do not have to worry about navigating the bus or affording a taxi.

References

1. Alberta Health Services. Integrated approach to indigenous health planning. Edmonton (AB): AHS; 2018. 59 p.

2. Truth and Reconciliation Commission of Canada. Truth and Reconciliation Commission of Canada: calls to action. Winnipeg (MB): Truth and Reconciliation Commission of Canada; 2015. 11 p.

3. Alberta Health Services. Indigenous health planning approach & guide. Edmonton (AB): AHS; 2018.

4. National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE protocol for responding to and assessing patients' assets, risks, and experiences: implementation and action toolkit. Bethesda (MD): NACHC; 2019 March. 126 p. Available from: http://www.nachc.org/research-and-data/prapare/toolkit/

5. Design Council. What is the framework for innovation? Design council's evolved Double Diamond [Internet]. London (UK): Design Council; 2019 [cited 2020 May 26] Available from: https://www.designcouncil.org.uk/news-opinion/what-framework-innovation-design-councils-evolved-double-diamond

6. Alberta Health Services. Co-design playbook: using integrated care partnerships to design better health. Edmonton (AB): AHS; 2019. 47 p. Available from: https://s3-us-west-2.amazonaws.com/transformativelearning/2019/test/Integrated+Care+Partnerships+Guide+DRAFT+1.1.6.9.pdf

7. Institute for Healthcare Improvement. Pathways to population health: an invitation to healthcare change agents. Boston (MA): IHI; 2017. 23 p. Available from: http://www.ihi.org/Topics/Population-health/Documents/PathwaystoPopulationHealth_Framework.pdf

8. Ivanov A, Voloshchuk M. Understanding Team Canvas [Internet]. Team Canvas; 2015 [cited 2020 May 25]. Available from: http://theteamcanvas.com/

9. Public Health Agency of Canada. Key element 3: base decisions on evidence [Internet]. Ottawa (ON): PHAC; 2014. Available from: https://cbpp-pcpe.phac-aspc.gc.ca/population-health-approach-organizing-framework/key-element-3-base-decisions-evidence/

10. Zarcarias D. 20 product prioritization techniques: a map and guided tour [Internet]. Daniel Zacarias; (n.d.). Available from: https://foldingburritos.com/product-prioritization-techniques/

11. Government of Alberta. Primary Care Network (PCN) profiles [Internet]. Government of Alberta; 2018 [cited 2020 May 26]. Available from: Alberta Open Government Program : https://open.alberta.ca/dataset?res_format=PDF&q=%22Primary+Care+Network+%28PCN%29+Profiles%22

12. Government of Alberta. Community profiles [Internet]. Government of Alberta; 2020 [cited 2020 May 26]. Available from: Alberta Open Government Program : https://open.alberta.ca/dataset?q=Community+Profiles&sort=score+desc&res_format=PDF

13. The Community ToolBox. Section 8. Identifying community assets and resources [Internet]. Lawrence (KS): University of Kansas; n.d. [cited 2020 May 25]. Available from: https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

14. Alberta Health Services. Step 2: understand your community [Internet]. Edmonton (AB): AHS; n.d. [cited 2020 May 25]. Available from: https://albertahealthycommunities.healthiertogether.ca/build-a-healthy-community/step-2-understand-your-community/

15. Bintz M. How can asset mapping improve community health [Internet]? Boston (MA): Institute for Healthcare Improvement; n.d. [cited 2020 May 26]. Available from: http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Bintz-AssetMapping.aspx

16. Metcalfe O, Higgins C, Lavin T. Health impact assessment guidance. Dublin: Institute of Public Health in Ireland; 2009. 47 p.

17. 100 Resilient Cities. Rotterdam resilience strategy: ready for the 21st century. New York (NY): 100 Resilient Cities; 2017. 126 p.

18. Riddell CA, Hutcheon JA, Dahlgren LS. Differences in obstetric care among nulliparous First Nations and non–First Nations women in British Columbia, Canada. CMAJ. 2016 Feb 2;188(2):E36-43.

19. Mind Tools. Force field analysis: analyzing the pressures for and against change [Internet]. Scotland: Mind Tools; n.d. [cited 2020 May 25]. Available from: https://www.mindtools.com/pages/article/newTED_06.htm

20. Tran N. Design thinking playbook for change management in K12 schools [video]. Palo Alto (CA): Issuu Inc.; 2016 [viewed 2020 May 25]. Available from: https://issuu.com/normantran2001/docs/design_thinking_playbook

21. Alberta Health Services. Improving integrated healthcare through community coalitions in Alberta. Edmonton (AB): AHS; 2019. 61 p.

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. Population, Public & Indigenous Health SCN. Indigenous Health Strategy: Making the Invisible Visible. Edmonton (AB): Alberta Health Services; 2020.

24. Project Canvas. 2016. Available from: http://www.projectcanvas.dk/

25. Health Quality Council of Alberta. Alberta quality matrix for health. Calgary (AB): HQCA; 2005. [cited 2020 Jun 8]. 1 p. Retrieved from: https://hqca.ca/wp content/uploads/2018/05/HQCA_11 x8_5_Matrix.pdf

26. The Community Toolbox. Section 2. Understanding and describing the community [Internet]. Lawrence (KS): University of Kansas; n.d. [cited 2020 May 25]. Available from: https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/describe-the-community/main

27. Magis K. Community resilience: an indicator of social sustainability. Soc Nat Resour. 2010 Apr 5;23(5):401-16. https://doi.org/10.1080/08941920903305674

28. Reid R, Haggerty J, McKendry R. Defusing the confusion: concepts and measures of contininuity of healthcare. Ottawa (ON): Canadian Health Services Research Foundation; 2002 Mar 01. 50 p.

29. Kania J, Kramer M. Collective Impact. Stanford (CA): Stanford Social Innovation Review; 2011. 41 p. Available from: https://ssir.org/articles/entry/collective_impact#

30. Tamarack Institute. Ideas: collective impact [Internet]. Waterloo (ON): Tamarack Institute; 2020 [cited 2020 May 26]. Available from: https://www.tamarackcommunity.ca/collectiveimpact

31. World Health Organization. Social determinants of health: key concepts [Internet]. Geneva: WHO; 2008 [cited 2020 May 26].2008; Available from: https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

32. World Health Organization. The implications for training of embracing a life course approach to health [brochure]. Geneva (CH): WHO; 2000. Available from: https://www.who.int/ageing/publications/lifecourse/alc_lifecourse_training_en.pdf

33. The SAGE encyclopedia of qualitative research methods. Thousand Oaks (CA): SAGE Publications; 2008.

34. Government of Canada. Indigenous peoples and communities [Internet]. Ottawa (ON): Government of Canada; n.d. [updated 2017 Dec 04; cited 2020 May 26] Available from: https://www.rcaanc-cirnac.gc.ca/eng/1100100013785/1529102490303

35. World Health Organization. Health systems strengthening glossary [Internet]. Geneva (CH): WHO; n.d. [cited 2020 May 26]. Available from: https://www.who.int/healthsystems/hss_glossary/en/index5.html

36. Alberta Primary Care Networks. Your medical home: what is a PCN [Internet]? Alberta PCNs; 2020 [cited 2020 May 26]. Available from: https://albertafindadoctor.ca/pcn

37. Boyd JM, Potestio ML, McDougall L. Population and public health: creating conditions for health and advancing health equity in Alberta. CMAJ. 2019 Dec 4;191(Suppl):S42-3.

38. 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.htm

39. Social Fabric. What's in a name [Intervnet]? Vancouver (BC) : Social Fabric; 2020 [cited 2020 May 26]. Available from: https://socialfabric.com/2011/06/whats-in-a-name/

40. Government of Canada. Stigma around substance use [Internet]. Ottawa (ON): Government of Canada; n.d. [updated 2020 Mar 10; cited 2020 May 26]. Available from https://www.canada.ca/en/health-canada/corporate/contact-us.html

41. Centers for Disease Control and Prevention. Well-being concepts [Internet]. Georgia (AT): CDC; n.d. [updated 2018 Oct 31; cited 2020 May 26]. Available from: https://www.cdc.gov/hrqol/wellbeing.htm

42. National Wellness Institute. The six dimensions of wellness [Internet]. Stevens Point (MI): NWI; 2020; n.d. [cited 2020 May 26]. Available from: https://www.nationalwellness.org/page/Six_Dimensions