

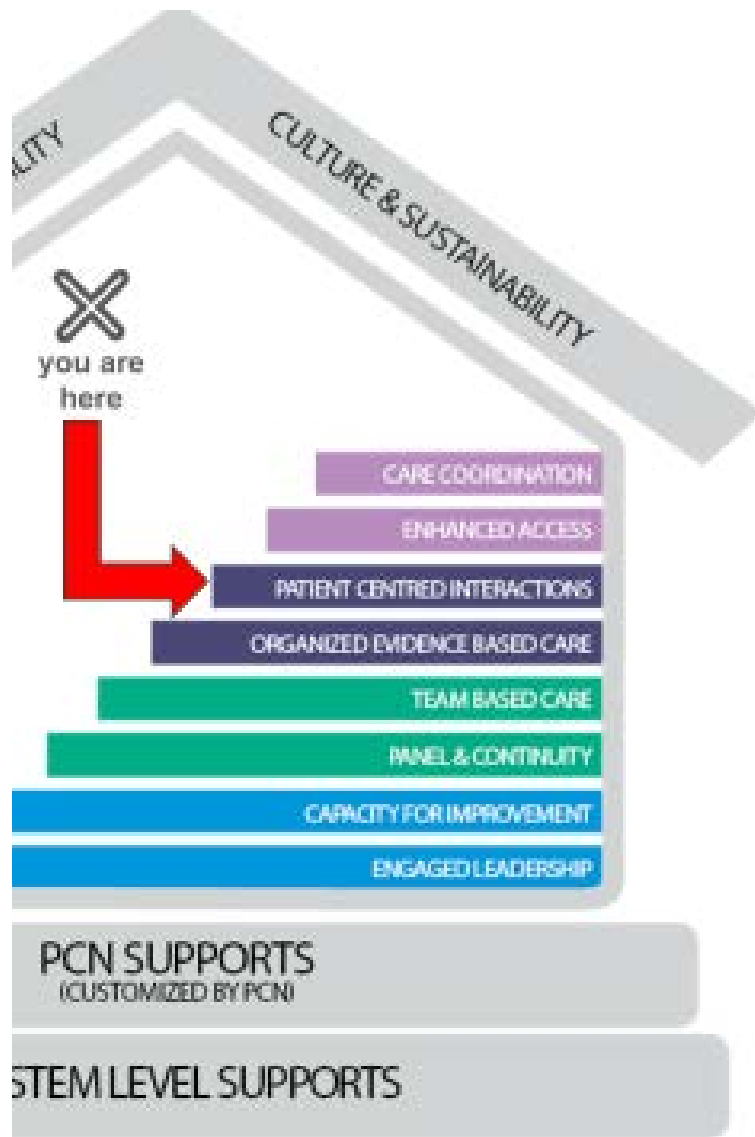
IMAGINE Citizens Collaborating for Health: PRIMARY HEALTHCARE ENGAGEMENT PROJECT

a grant funded project through AH

**PCN Strategic Leadership Forum
February 2018**

PRESENTERS / DISCLOSURES:

- Dr. Christine Luelo – MD CCFP , Medical Director SCPCN, CoChair Calgary Zone Governance Committee Secretariat, Steering Committee member
 - No financial or in kind incentives
- Judy Birdsell – CoChair Imagine , CoChair Steering Committee PHC Engagement Project
 - No financial or in kind incentives



Who is IMAGINE?:

- Independent group of citizens with a vision for a health care system that is designed, and care that is delivered, in partnership with citizens, achieving the best possible experiences and outcomes for patients.



THE PRIMARY HEALTH CARE VISION FOR ALBERTA:

“The primary health care system is organized, connected, integrated and coordinated with other parts of the health care system and with community and social services.

Albertans are able to build and maintain relationships with their health care team. “

*(Alberta's Primary Health Care Strategy,
Alberta Health, January 2014)*

PROJECT OBJECTIVES:

- Understand stakeholder **awareness, values, and perceptions** related to continuity of care concepts of **patient attachment** and health home
- Provide participants with an **evidence-based understanding** of patient attachment and health home concepts
- **Collect diverse stakeholder experiences** related to patient attachment and health home concepts
- Provide participants with opportunities to **contribute recommendations** regarding the **implementation** of patient attachment and health home concepts

PROJECT DESIGN:

- April –October 2017 – report November 2017
- Extensive literature review
- **31 diverse Albertans** from an initial pool of over 350 volunteer applicants via online application process
- 23 female, 8 male/ 11 rural/ 20 urban (Lethbridge, Calgary, Grand Prairie, Fort McMurray, Red Deer and Edmonton)
- Age 18-75+
- One-on-one semi structured interviews, two webinars/teleconferences, and a face to face full day workshop on September 30, 2017, and a third and final teleconference to validate report

RECOMMENDATIONS :

- Concepts
- Continuity of care
- Patients as partners
- Other recommendations

RECOMMENDATIONS - CONCEPTS:

- Foundational concepts:
 - **Do not teach definitions – show how** primary health care, primary care networks or a health-home work through demonstrations and stories
 - Keep **messages simple and easy to understand**
 - Provide translations in majority of ethnic languages

RECOMMENDATIONS - CONCEPTS:

- Attachment:
 - **Avoid the word attachment**
 - Instead use words such as : relationship, trust, value, link and connected
 - Answer the question – **attached to what or whom?**
 - **Explain how** – especially in rural communities
 - Provide evidence and statistics around benefits including cost effectiveness and continuity of care

RECOMMENDATIONS - CONCEPTS:

- Health home:
 - Provide individuals and communities with opportunities to share stories and then reflect on the new model in that context
 - **Leverage existing Alberta models** of health home – share patient and provider experiences about these models
 - **Demonstrate how it supports continuity of care**

RECOMMENDATIONS – CONTINUITY OF CARE:

- Information access and sharing:
 - **Have a plan** for a functioning information technology transfer system in alignment with attachment and health home implementation
 - Create a technology system with patients not for patients(and not just for providers)
 - **Empower front line employees and providers to provide more and better information**

“Attachment by information”

RECOMMENDATIONS – CONTINUITY OF CARE:

- Ease of navigation:
 - The system is not navigable and we need to make it that way by working directly with individuals and communities
 - **Providers or a main point of contact on a care team** should typically play the lead role in navigation support. However complex health situations and specific communities may need formal navigation support such as **navigators or health brokers**.

RECOMMENDATIONS – CONTINUITY OF CARE:

- Relationships and trust:
 - Explain how **quality of care will be assessed and measured** under the new model
 - **Ensure there is flexibility** within the new model and clearly explain what that looks like
 - Create inclusive and meaningful opportunities for **dialogue to build trust**

RECOMMENDATIONS – PATIENTS AS PARTNERS:

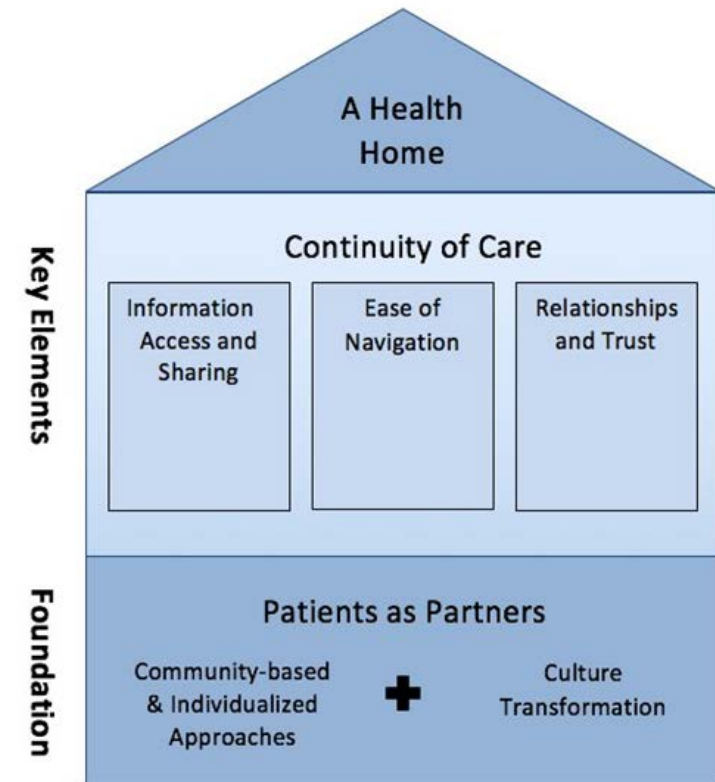
- Implement the new models with patients
- Pay special attention to the needs of rural Albertans and unique communities
- Seek the guidance of and work with community-based organizations and institutions
- **Be transparent about physician funding**
- Ensure administration, providers and front line employees are speaking from the same script

RECOMMENDATIONS - OTHER:

- Be open to community-led solutions – find ways to **more effectively spread** what works in one community or sector
- Seek the input and guidance of **community-based organizations and institutions**
- There is a deep concern about mental health support – demonstrate your commitment to improving **mental health care**
- Be transparent about physician funding and how it will work in the new model
- **Ensure administration, providers and front line employees are all speaking for the same script with the same, correct information**

ALBERTA HEALTH FEEDBACK ON RESULTS:

- Feb12, 2018 meeting with IMAGINE co-chairs to review report
- Communications plan will be informed by report results.
- Ongoing dialogue between IMAGINE and AH as this is rolled out to garner feedback on reception



IMPLICATIONS FOR PCN'S/ PHYSICIANS:

- Implementation of medical home through PCN structures – business planning
- Implementation of medical home within physician practices – conversation with patients
- Participation in CPAR - what's in a name?
- Zonal communication plans in general



QUESTIONS?





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