Report to Alberta Health

Primary Healthcare Engagement Project

Executive Summary

January 25, 2018

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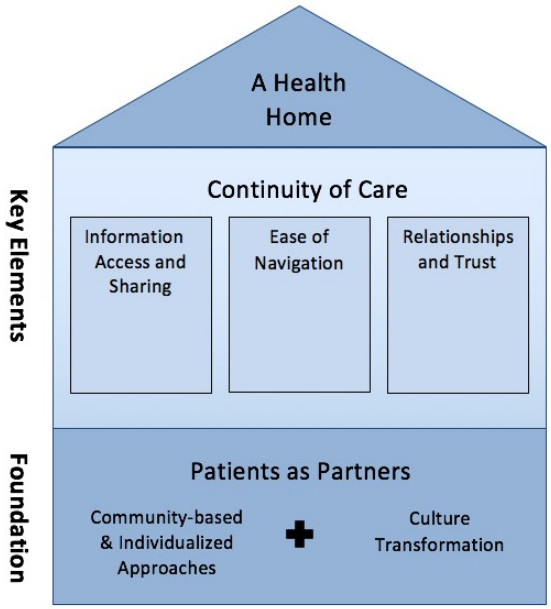
In collaboration with partners, IMAGINE led the Primary Health Care Project (PHC Project) to engage Albertans and seek insight and input into the concepts of attachment and health home in the context of Alberta's primary healthcare system. The purpose of the PHC Project was to inform future steps as Alberta Health explores the health home model along with methods and strategies to communicate it to citizens

The PHC Project brought together 31 diverse Albertans from across the province through a focused, in-depth, engagement process. The project provided comprehensive opportunities for participants to review evidence and ask questions. It consisted of three participant-wide webinars or teleconferences, one-to-one qualitative interviews and a participatory, narrative-based workshop.

Understanding of foundational healthcare concepts
Insight into participant understanding and awareness of foundational project concepts was assessed. Participants were generally aware of the terms primary care, primary healthcare and primary care networks but unable to articulate clear definitions or distinctions of the terms. Most were unfamiliar with the new concepts of attachment and health home. Their perceptions of the two concepts were linked to either negative or positive personal experiences in the system. The concept and term attachment evoked many hesitations. Some were related to the "confining" or "needy" nature of the term and other concerns came from those in rural communities who questioned the viability of attachment limited access to primary care providers. Participants felt more comfortable with the idea of attachment when discussed in the context of a health home of which the concept evoked primarily positive responses.

The Elements and Foundation of a Health Home with Attachment
Engagement methods used in the project revealed three key elements of a health home and attachment (information access and sharing, ease of navigation and, relationships and trust), all captured within a broader desired outcome of continuity of care; information access and sharing, ease of navigation, and, relationships and trust. Each of these elements is needed to provide continuous, quality care. The foundation supporting these elements is having patients as partners. And, having patients as partners relies on building blocks of community-based and individualized approaches and culture transformation.

Elements and Foundation of a Health Home



Continuity of Care
While participants rarely used the term "continuity of care," the desire and need for it was clear. Participants focused on three key elements, outlined below, required for to achieve continuity of care and a health home.

- Information Access and Sharing*:* Participants want access to information and/or personal records and they also want to know that all their providers have access to that information. Participants acknowledged the need to take personal responsibility for understanding and monitoring their own healthcare but, they want the tools and access to their records to support that.

- Ease of Navigation: Participants universally expressed concern about the navigational challenges in our health system. The workshop process demonstrated that navigating through the healthcare system is as much a community or network effort as it is an individual one.

- Relationships and Trust: Participants value strong relationships with providers and want to know how quality of relationships and ultimately care will be measured and assessed within a health home with attachment.

Patients as partners
Connecting the key elements above to action means patients are at the core. Patients as partners is the foundation of building a health home and uses the building blocks of community-based and individualized approaches and culture transformation.

- Community-based approaches: Recognizing the unique needs of rural communities and working with them individually was a strong project message. It is also important to work with communities that represent a variety of demographics or situations. Collaborating with community-based organizations was identified as an important aspect of connecting with and creating solutions for specific communities as well as individuals.

- Individualized approaches: The system and its providers must take the whole person into account. Participants recognized that individual approaches support quality of care; patients access the right provider or service at the right time. Attachment itself requires individualized approaches, taking into consideration personal situations and the desire for flexibility.

- Culture transformation: Changing the culture of Alberta's health care is a priority. Many participants pointed out that without culture change along with full system awareness, understanding and buy-in, attempts to implement the concepts of health home and attachment would fail. Participants want changes that result in both providers and the system, in general, being open to their knowledge and ideas.

Recommendations
Providing participants with opportunities to contribute recommendations regarding the implementation of patient attachment and health home concepts was a key objective of this project. A brief synopsis of recommendations is outlined in the table below.

Theme	Recommendations
Foundational healthcare concepts	*Primary care, primary healthcare, primary care networks* • Do not teach definitions. Show how the concepts work through demonstration and stories. • Keep messages simple and easy to understand. • Provide translations in majority of ethnic languages. *Attachment* • Avoid the word attachment.

Theme	Recommendations
	• Use words such as: relationship(s), trust, value, link and connected. • Use stories and demonstration to convey the concepts. • Answer the question – attached to what or whom? • Explain how – especially in rural communities. • Explain flexibility and choices. • Explain attachment concept within the context of health home. • Provide evidence and statistics around benefits including cost effectiveness and continuity of care. *Health home* • Provide individuals and communities with opportunities to share their stories and reflect on the new model in that context. • Leverage existing Alberta models of health home. Share patient and provider experiences about these models.
Continuity of care	*Information access and sharing* • Have a plan for a functioning information technology system in alignment with attachment and health home implementation. • Create a technology system <u>with</u> patients not for patients. • Empower front-line employees and providers to provide more and better information. *Ease of navigation* • Work directly with individuals and communities to make the system more navigable • Providers or a main point of contact on a care team should play the lead role in navigation support. Complex health situations and specific communities may need formal navigation support. *Relationships and trust* • Explain how quality of care will be assessed and measured. • Ensure there is flexibility and clearly explain what that looks like. • Create inclusive and meaningful opportunities for dialogue.
Patients as Partners	• Implement the new model <u>with</u> patients, not just for patients. • Pay special attention to the needs of rural Albertans and unique cultural communities. • Seek the guidance of and work with community-based organizations and institutions. • Ensure administration, providers and front-line employees are speaking from the same script.