Targeted Chronic Disease Prevention and Management Approaches for Diverse and Vulnerable Populations in Alberta

A patient-Centred care framework and Action plan for Alberta

An Overview

Diverse Populations
Chronic Disease Management
Primary and Community Care

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1. **Background - Why a Targeted Provincial Chronic Disease Care Framework?**

**Alberta’s Global Village Reality**

Alberta is rapidly becoming more diverse in its population. Provincially, in 2006, 13.9% belonged to a visible minority, 16.3% were immigrants, 6% self-identified as Aboriginal, 2% Francophone, 8,400 were homeless, 18% lived in rural settings, 22,785 were Mennonites, 12,330 were Hutterites, and 17% lived with disability. The diversity of Alberta’s population will continue to increase significantly during the next few decades.

The increasing prevalence of chronic diseases among Albertans is a key challenge for the province; however, there are strong indications that compared with the general population, vulnerable segments of diverse populations such as Aboriginal people, immigrants, refugees, specific visible minorities and people experiencing homelessness are disproportionately impacted by chronic disease. Diabetes, obesity and cardiovascular disease rates are three to five times higher among specific populations.

**The Challenge**

Alberta has been a leader in developing transformational approaches to chronic disease care in both primary care and AHS services; however, despite high needs, access to appropriate and quality chronic disease services, information and resources is a major concern for vulnerable segments of diverse populations, particularly for Aboriginal and non-Aboriginal people living in remote parts of Alberta. The access challenges in these communities stem from multiple factors: geographic remoteness, socio-cultural, financial, environmental and systematic factors related to the way that primary health care are provided in Alberta. These challenges put vulnerable populations at a greater disadvantage in terms of getting support to prevent and manage chronic diseases. As a result, chronic diseases in these vulnerable populations are under-diagnosed and undertreated. Alberta Health Services is faced with the challenge of effectively caring for patients with different socio-economic backgrounds and circumstances.

Limited number of Alberta Health Services initiatives and Primary Care Networks (PCNs) have successfully adopted and implemented modified elements of the Expanded Chronic Care Model to address access challenges and achieve enhanced access and improvements in the quality of chronic disease care for diverse and vulnerable populations. Overall, the unique needs of vulnerable segments of diverse populations in Alberta have been effectively been reflected in provincial planning, policy/decision making and service provision.

**Overall, the unique needs of the diverse and vulnerable populations have not effectively been reflected in provincial planning, policy/decision making and service provision**
**Organizational Response**

As an organization, Alberta Health Services recognizes that within Alberta there are specific populations that have unique social, cultural and economic needs and they require targeted and customized approaches to meeting their health care needs (Alberta Health Services Strategic Direction 2009-2012). Therefore, it is imperative that our healthcare policies and strategies are targeted appropriately to address and reflect the unique needs of diverse and vulnerable populations.

Differences across the province related to population diversity and level and nature of vulnerability patterns suggest that healthcare service delivery models need to be tailored to match the local needs of each geographic, zone and diverse community. As per its mandate and in collaboration with key internal and external stakeholders, the **Provincial Diverse Populations Strategy** within the Chronic Disease Management pillar of the Primary and Community Care Portfolio, has extensively examined these gaps and using the principles of the Expanded Chronic Care Model as the guiding framework, has developed targeted and patient-centered, approaches that act on a number of Social Determinants of Health (for example: health services, socio-economic status, education, income, culture and Aboriginal status) to ensure enhanced and equitable access and outcomes for Alberta’s diverse and vulnerable populations. In alignment with the AHS and portfolio values, strong community engagement and patient, family, community centeredness are foundational to this strategy. The **Aboriginal, Ethno-cultural, Francophone, Hutterites/Low German Speaking Mennonites and Homeless people** were identified as priority populations for targeted programming in Alberta.


*In 2010, a provincial Working Group (AHS Primary Care and Chronic Disease Management for Diverse and Vulnerable Populations) and 5 expert sub-working groups with broad representation from AHS and community stakeholders were formed. These groups were tasked with addressing the service gaps and needs of the diverse and vulnerable populations in Alberta and supporting development of targeted provincial models that match local and diverse needs. The provincial working group and 5 sub-working groups played an integral role in development foundational initiatives and evidence that informed and influenced the development of the “A Targeted Chronic Disease Prevention and Management Approaches for Diverse and Vulnerable Populations – A Patient-centred Framework and Action Plan for Alberta”.*

**Our Partners**

- The zones
- AHS portfolios
- Diverse community partners: Francophone, ethnic, homeless, Hutterite & Mennonite
- Front line professionals
- Physicians
- Aboriginal communities: First Nations, Métis Settlements
- National/international sectors
- Health Canada, PHAC
- Academia/research community
- Special community groups
This provincial framework has a firm foundation as it is based on a number of stakeholder consultations and several key foundational considerations such as demographics of Alberta’s diverse populations, inventory of current targeted services, assessment and identification of service gaps and needs of diverse and vulnerable populations and, lessons from evidence-based best and promising primary care and chronic disease prevention and management practices for diverse and vulnerable populations.

The framework and its five strategic priorities and opportunities for action highlight the need to take specific and concrete actions on the identified cultural, linguistic, social, geographic, economic and other broader determinants that seem to impede access of the diverse and vulnerable populations to appropriate health services and built on evidence from best and promising practices to improve access and outcomes for diverse and vulnerable populations.

This framework is both strategic, in that it provides general direction in moving forward towards reducing service gaps, and action oriented to support the AHS zones and other service providers in putting the recommend strategies into practice. It is intended to support the AHS zones, key stakeholders and communities in implementing accessible, sustainable and innovative programs for diverse and vulnerable populations. This will be accomplished by way of five strategic priorities:

**Strategic Priority 1 - Promoting health equity in patient care**

**Objective** - To ensure that decisions, policies and resources are positioned appropriately to ensure equity in chronic disease care at all levels (Provincial, Zones, Local, Strategic Clinical Networks, Primary Care, Standards and Policy)

**Strategic Priority 2 - Community engagement and partnerships**

**Objective** - To develop participatory and collaborative partnerships with patients, communities and key stakeholders to effectively plan and deliver health services for diverse and vulnerable populations. Active involvement of local communities is needed to improve the responsiveness of the health care to local needs

**Strategic Priority 3 – Equitable access and utilization**

**Objective** - To ensure that diverse and vulnerable populations have equitable access to primary care and chronic disease prevention and management services, information and support.

**Strategic Priority 4 - Equitable quality of care**

**Objective** - To ensure that targeted services for diverse and vulnerable populations are provided in a coordinated manner and culturally safe environment. Assessment of each patient’s unique needs and effective patient/provider interactions are foundational to this strategic area.

**Strategic Priority 5 - Research and evaluation**

**Objective** – To ensure access is appropriate, service delivery approaches must be evidence-based and supported by research and evaluation to ensure they reflect the best and promising practices and are relevant to Alberta’s diverse and vulnerable populations.

**Anticipated Impact and Outcomes** - Positive health outcomes, satisfaction and compliance are closely related to the effectiveness and responsiveness of services to patients’ unique needs. The exact impact of the proposed framework in terms of improved patient outcomes and actual savings to
the organization is difficult to estimate at this point, however, based on the outcomes from similar approaches, it is expected that the implementation of the strategic priorities will show positive impacts within 3-5 years and the effectiveness of the programs will continue to improve. Critical to the success of the framework is executive support and active involvement of local diverse communities and providers.

For more information about the Framework, contact:

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Alberta Health Services

Community

Vision
Enhanced health for Diverse Populations

Guiding Principles
Patient & family centered; Community Engagement; Local Planning and Delivery; Socio-culturally Responsive; Holistic; Accessible and Equitable; Innovative; Integrated; Sustainable; Evidence-based

Organizational Alignment
AHS Strategic Direction, the Best We Can, Health Plan, CDM Strategic Direction

Strategic Direction
The Social Determinants of Health Approach

Strategic Priorities
Health Equity in Chronic Disease Care
Community Engagement
Equitable Access and Utilization
Equitable Quality of Care
Research and Evaluation

Expected Outcomes
Enhanced health, access and equitable health outcomes for diverse populations in Alberta