

Zone Primary Health and Public Health teams are also collaborating to ensure integrated services will be delivered. As the pilot project proceeds, resources and tools will be developed to allow for spread of this approach more broadly.

This project will be piloted with three PCN-Zone-Community sites in Alberta:

- McLeod River Primary Care Network – AHS North Zone – Whitecourt
- St. Albert Sturgeon Primary Care Network – AHS Edmonton Zone – Morinville
- Kalyna Country Primary Care Network – AHS Central Zone – Vermilion and Viking

These sites responded to the call to action and indicated they are:

- Serving individuals impacted by financial strain;
- Willing to partner with community groups to test new ground to improve supports and make connections for individuals for whom income is a barrier to health;
- Willing to identify gaps, coordinate services and/or partner to strengthen community capacity to address the health impacts of financial strain.

The Project Support Team made up of the AHS Provincial Population, Public and Indigenous Health and Primary Health Care programs and their Strategic Clinical (PPIH SCN) and Integration (PHC IN) Networks, and the Alberta Medical Association (AMA) began working with the participating PCNs and clinics and communities in January 2019 and will continue until March 2021.

Project Approach

The goal of the RIFS project is to reduce financial strain as a barrier to health, particularly in the areas of cancer and chronic disease risk.

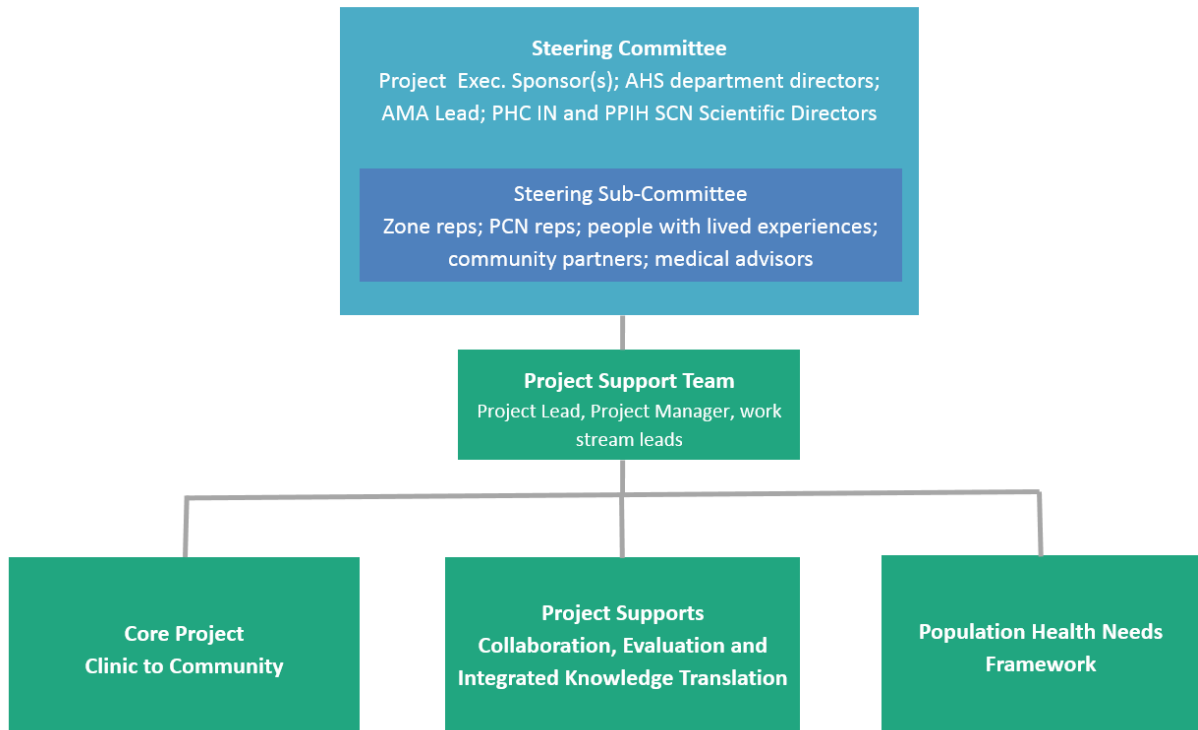
The project support team's approach will be to enhance partnership across the continuum from community to clinic and build on existing infrastructure, readiness and work already underway. The project will be co-designed locally with each clinic - PCN - community partnership and will include: clinical screening for financial strain; community asset mapping to better link practice teams to clinical and community supports; a community development approach to addressing the gaps for those living with financial strain and the development of a lasting infrastructure for sustained and supportive partnership across population, and public health and primary health care.

The **high-level project objectives** are as follows:

- Identify patients living with financial strain through screening within primary care settings.
- Increase awareness of appropriate clinical interventions and community-based supports that address basic unmet needs.
- Identify and design coordinated care approaches that address unmet needs within medical, community and zone services.
- Increase adoption of a community development approach to enhance community actions that effectively support those who experience financial strain.
- Develop a population health needs framework to guide health service planning across the health care system.
- Foster effective, ongoing, collaborative relationships among partners to Reduce the Impact of Financial Strain.

Project Governance

The RIFS project is overseen by a Steering Committee and Sub-Committee made up of the AHS and AMA project executive sponsors, organizational leaders and scientific offices as well as AHS Zone and PCN representatives, community partners, medical advisors, and people with lived experiences. The core project support team is made up of a Project Lead and Project Manager and leads from each of the project areas of work. Three major areas of work are the Core Project, which involved the clinical screening to community development continuum; the Project Supports including project collaboration, evaluation and integrated knowledge translation, and the population health needs framework. Project team members work collaboratively to meet the needs of the project's goal and objectives.



Project Areas of Work

Identifying, planning and supporting patients living with financial strain

Poverty: A Clinical Tool for Primary Care Providers (AB) (CEP, 2016) will be implemented in primary care practices to screen, identify and support patients living with financial strain. Primary care teams will help to co-design processes that help to implement the screening tool and link patients to community supports.

Improvement Facilitator Training provided by Alberta Medical Association focuses on how to facilitate changes within primary care practices. This may include how to initiate a conversation about financial strain, why this is important, how it affects health and health care planning, and what role primary care can play. Supporting primary care providers to initiate conversations with their patients about financial strain is an important step in

changing the conversation we have as a health system, and a society, about what determines health. It also improves the overall experience of patients. The sensitive nature of the issue can pose unique challenges, so training may include how to elicit and respond to patient's income concerns so as not to create unintended negative consequences.

PCNs will also be supported in facilitating change to develop work processes. These processes may include identifying improvement opportunities to plan with and manage patients including clarifying team roles and integrating data within the Electronic Medical Record.

The College of Family Physicians of Canada (CFPC, 2015) recommends educating patients about available income supports and linking patients and families to key primary care and community resources to optimize income (e.g. services such as Alberta Supports or those that provide assistance in completing tax returns to access income benefits). The CFPC also recommends helping patients with income challenges overcome specific barriers related to modifiable risk factors such as healthy eating and being active. To better understand barriers patients living with financial strain face, patient interviews will be considered where able (conducted by evaluation and measurement team members) to provide information important to community development strategies, to improve supports available in the communities.

Strengthen integrated care partnerships with services and resources in the community.

To strengthen relationships between PCNs, member clinics and the communities they serve, linkages to the services, programs and resources available within the Patient's Medical Home¹ will be assessed. This moves beyond partnership with health service providers to include other human service sectors and community organizations. Within the timeline of this project, we propose a community facilitator or coordinator undertake community asset mapping and build relationships in a sustainable way to position the PCN and associated practice teams to be better linked with their communities. PCN and practices teams' enhanced understanding of the broader community will assist in strategizing outreach plans and partnering with relevant community organizations. Community organizations may develop a stronger understanding of patient/community member needs and tailor their services accordingly.

¹ <https://www.albertadoctors.org/leaders-partners/innovation-in-primary-care/patients-medical-home>

Use the Alberta Healthy Communities Approach to support individuals experiencing financial strain) and promote overall health

Leveraging existing knowledge, skills, and tools developed as part of the Alberta Healthy Communities Approach, PCNs and local organizations have an opportunity to enhance the health promoting assets that are located in their communities. Initially with support from community facilitators, community members and inter-sectoral partners will be brought together to foster local community connections. The community team will identify local assets and opportunities within broader community and consider the unique needs of patients living with financial strain. Using evidence and practice informed resources, the community will create an action and evaluation plan to implement changes in the social, physical, economic, and/or policy environments that support those living with financial strain. Communities may choose to act on determinants of health linked to income such as employment, education, and social supports that will impact all citizens living within their communities. Communities will then be supported to implement action over the course of the project lifespan. Mechanisms for taking action include leveraging existing community connections and services, community engagement, inter-sectoral collaboration, asset-based community development, political commitment and healthy public policy. This work will have the added benefit of augmenting relationships, connections and processes required to keep PCNs up to date on available community resources. Developmental dollars from the grant will be allocated to community organizations to undertake community driven initiatives to reduce financial strain and promote health. It is through this work that we will create the social, physical, and economic and policy environments necessary to reduce the health impacts of financial strain for the longer term.

Develop a population health needs framework that incorporates primary care's lens of patient panels and test its usefulness during health service planning

The new PCN Governance Framework calls for zone-wide service plans and PCN business plans that are aligned to the health needs of the population and aligned with AHS community programs and services. To achieve this, a framework for determining health needs of the population is needed that is agreed upon by primary care and population health. This framework can also form the evidence-based foundation for future collaborative action regarding the impact of financial strain on cancer, chronic disease, and other health outcomes in Alberta.

Understanding PCN-level population health needs requires a blended consideration of patient panel data and data from relevant community-based geographic boundaries. The work in this stream will draw on the recently launched Community Cancer Prevention (CCP) and Screening Dashboard that provides Alberta communities with access to their own local comprehensive, interactive cancer prevention and screening profiles including social determinants. This work stream will also leverage practice level EMRs and patient paneling.

PPIH Population Health Surveillance and Infrastructure will collaborate with the ACPLF, and AHS Primary Health Care along with PCNs and zone partners to develop the framework and delineate functional themes, indicators, measures, and data sources. They will also develop a methodology to populate PCN-level population health profiles that incorporate primary care's lens of patient panels with relevant data from community-based geographic boundaries. The framework will then be tested with several PCNs to confirm feasibility, acceptability, and usefulness. Requirements for incorporating PCN-level population health profiles in the dashboard will also be developed.

Build a sustainable approach to population/public health and primary care collaboration

Collaborative governance and processes will be established at the outset of the project. Actions will be taken to promote and sustain an active, productive working relationship and to formulate knowledge translation activities that foster continued and expanded cross-cutting partnerships within the health system. Evaluation will assess the impact and outcomes of the partnership across two components of Alberta Health Services (PPIH and PHC) as well as with the Alberta Medical Association, AHS Zones, and primary care and community partners.

Evaluation

PaCT, ASaP and PPIH evaluation teams will contribute their knowledge and expertise to the development of an evaluation plan to measure outputs, short-term outcomes, and lay the foundation for long-term impacts. Implementation of an evaluation plan, based on the RE-AIM Framework, and responsive adaptations to the plan as the project is implemented is critical to the planned spread and scale process for the project.

Integrated Knowledge Translation

The project is taking an integrated knowledge translation (IKT) approach, meaning the project team is collaborating with end users from the beginning to define the problem and design the intervention. We will continue collaborating regarding tool development, evaluation, data collection, and interpretation, and dissemination of findings. A full IKT plan will be developed as part of the overall project implementation and evaluation plan. It will delineate audiences, anticipate learnings, and define KT strategies and timelines.

Several existing and ongoing KT vehicles and opportunities will be leveraged:

- The Healthy Communities Hub (Alberta Prevents Cancer, 2017) will house and provide province-wide access to community experiences and stories.
- The Alberta Healthy Communities Approach includes a network of Health Promotion Facilitators active in 18 communities with ongoing team development opportunities.
- The partnership of the PPIH SCN and the PHC IN provides access to a network of partners within AHS, the academic community, provincial and federal departments, community organizations and professional associations.
- The central role of the Alberta Medical Association provides a key connection to primary care providers throughout the province.
- Information sharing infrastructure set up through the PaCT initiative can be used to share experiences and promote uptake of similar activities
- Primary health care and public health zone and provincial council meetings offer an opportunity to share promising practices between zone primary care and chronic disease management leadership.
- Additional opportunities will be explored with the new joint AHS/PCN governance structure (provincial and zonal)

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Key Links:

Poverty: A Clinical Tool for Primary Care Providers. Centre for Effective Practice
<https://cep.health/clinical-products/poverty-a-clinical-tool-for-primary-care-providers/?®ion=5>

Patients Collaborating With Teams PaCT Initiative <http://www.topalbertadoctors.org/pact/>

Alberta Healthy Communities Approach. <http://www.albertapreventscancer.ca/community/>