Better Quality, Better Outcomes, Better Value

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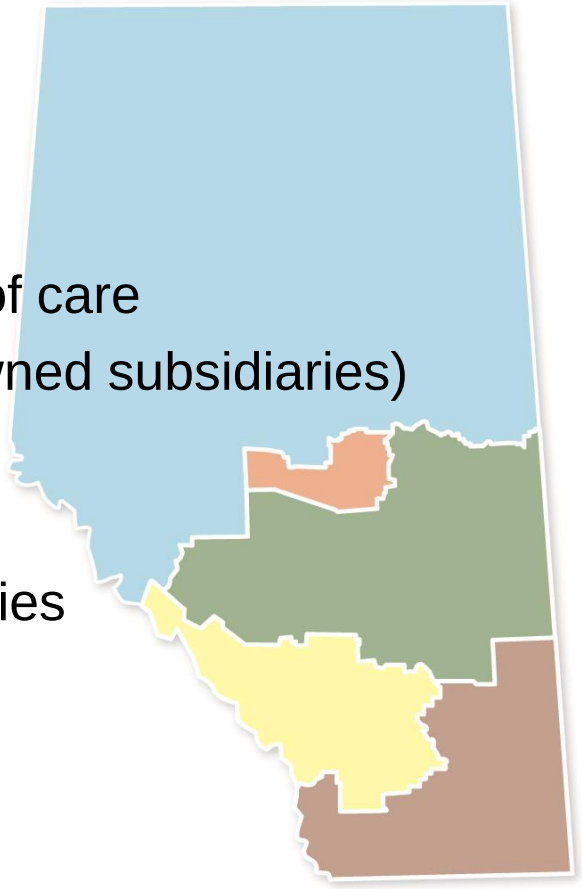
Alberta Health Services – A Snapshot

- Single provincial health care agency
  - 3.9 million Albertans
  - 661,848 kms²
- Key service provider – spanning the continuum of care
- 104,000 staff (direct employees and in wholly owned subsidiaries)
- 8,400 physicians
- Almost 18,000 volunteers
- Programs and services offered at over 450 facilities
- 100 hospitals
- $13.3 billion operating budget



Context for Change

- Demographics
- Public Expectations
- Prevalence of Conditions/Disease
- Structural Changes in Alberta Government Revenue
- Need for Clinical Appropriateness (pathway adoption, technology adoption and laboratory and diagnostic imaging utilization)
- Fragmentation across the continuum of care
- Need for appropriate care, appropriate setting and appropriate workforce utilization across the system
- Complex, high needs populations
- Efficiency and productivity gains required
- Cost structure

Marcus' story – today

Marcus is a 47 year old man with two young children who like to play hockey and baseball. He has a caring wife with whom he lives. He has had difficulty maintaining a job given his attendance record.

Last year Marcus visited various emergency departments over 100 times. He had 17 admissions to hospitals for a total of 49 days in hospital. He has a mental illness and Crohn's Disease. He visits the emergency department more times than the average person goes to the grocery store—more than two times per week. He is admitted to hospital more than one time per month.

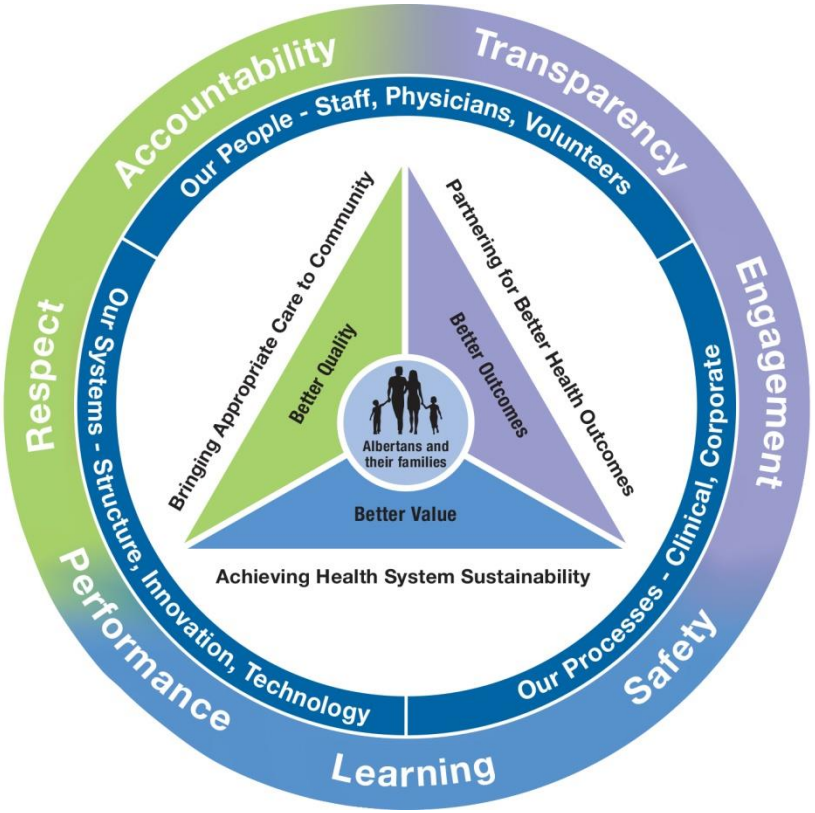
The system is not working for Marcus.

Developing the AHS Health Plan

- Collaborative planning with Alberta Health
- Consideration of the drivers for change
- Approach based on “triple aim”
- Three strategic directions (AH and AHS)
- Validation and listening through engagement with senior leaders, clinicians and operations
- Alignment of work streams
- Development of major activities to meet the strategic directions and address the drivers
- New performance measures and outcomes framework

Strategic Directions

- Bringing appropriate care to the community
- Partnering for better health outcomes
- Achieving health system sustainability



Bringing appropriate care to the community

- Strengthen community and primary health care
  - Develop innovative service delivery models
  - Increase service integration and accountability
  - Work across ministries

- Implement continuing care plan, and the provincial addiction and mental health strategy

Partnering for better health outcomes

- Strategic Clinical Networks
- Model of care transformation
- Prevention and early detection
- Partners in health
- Clinical information systems
- Health technology assessment
- Cancer strategy

Achieving health system sustainability

- Scheduling and rotation management
- Innovation, productivity and efficiency in acute care service delivery
- Medication management
- Aligning needs, service models and point of delivery
- Measuring outcomes
- Funding models

Key work streams

1. Delivering innovative service models for complex high needs populations
2. Strengthening community and primary health care
3. Advancing the adoption of evidence-informed practices and clinical appropriateness
4. Implementing new funding models and revenue initiatives
5. Optimizing service delivery
6. Driving productivity improvements
7. Containing costs

Measuring our performance

- To ensure we are meeting our goals and Albertans' expectations, we have to be able to measure our performance
- The 2013-2016 Health Plan and Business Plan outlines new (strategic) performance measures to help us determine our success
- The performance measures in the 2013-2016 Health Plan and Business Plan include a range of indicators such as: patient satisfaction, access, and average length of stay/expected length of stay ratio in acute care facilities
- Targets will be established and progress will be reported

Guiding Principles for Implementation

Patient Care:

- Act thoughtfully with safe, quality patient care and health outcomes at the forefront of decisions.

Our Staff / Physicians and Volunteers:

- Treat all staff, physicians and volunteers in accordance with our values.

Overall:

- Adopt a strong “Focus and Finish” - disciplined approach to prioritizing, creating capacity and aligning budget to complete initiatives.
- Optimize our single provincial health care system

Action Plan 2013-14

- An additional document, the Action Plan 2013-14, has been developed to provide a snapshot of initiatives, key deliverables and dates for 2013-14.

- Executive leads accountable for delivering on the described actions are identified.

- The Action Plan is a public document and we are accountable for the achieving the deliverables and results described.

Innovative Service Models

- Complex High Needs Populations (CHNP)
  - Population defined in terms of costs attributed at patient level
  - $9.6B costs allocated
  - Top 5 % of population in terms of these total costs identified
  - This populations consumes 66% of total costs
  - Health Service Areas will be examined for opportunities
  - Identified clusters using hierarchical cluster analyses
  - Clustering based on demographics and chronic/episodic diseases

CHNP – An example

- Population of 74,000 in specific geography
- Larger proportion adults 20-60
- Less children than the average
- Similar proportion of 65+ compared to Alberta
- Higher than average male population (54%)
- Morbidity index amongst the highest in the province
- Residents have much higher inpatient bed utilization:
- 12% more in-patient separations

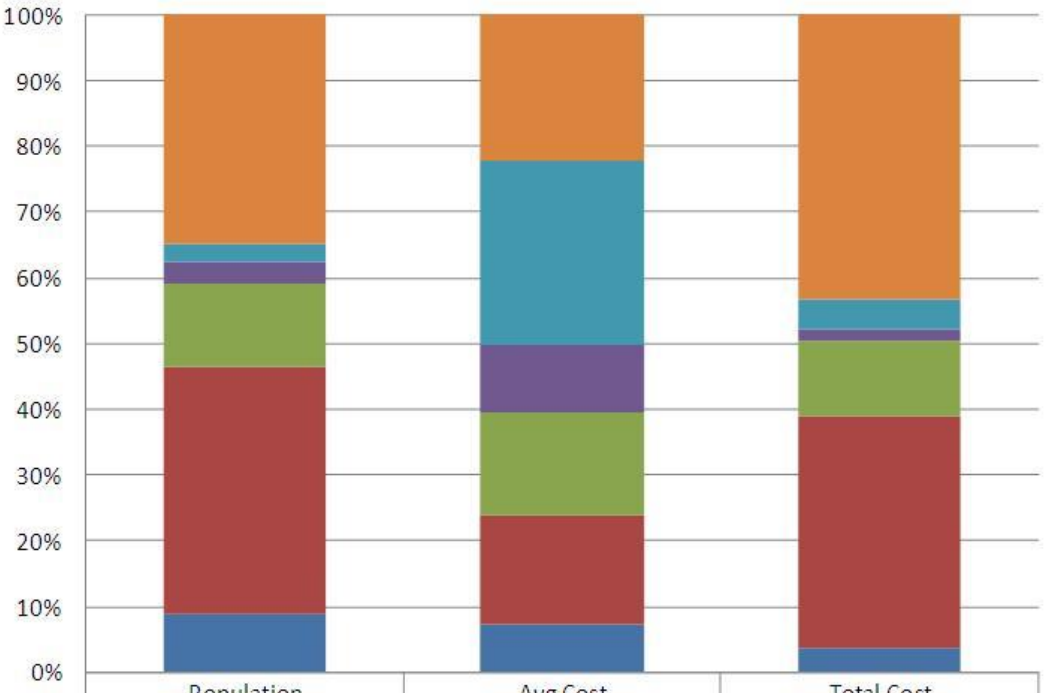
CHNP – An example

- 69% more inpatient days
- Higher GP utilization rate than provincial average (9% higher)
- Higher specialist utilization rate than provincial average (40% higher)
- Higher proportion with significant chronic and catastrophic conditions
- Prevalence comparisons shows residents have much higher rates of mental health conditions, substance use, social issues, COPD, neurological diagnoses, diabetes
- Population costs 30% more per capita
- Among 74K population 4623 identified CHNP (6.8%)

COMPLEX HIGH NEEDS POPULATION CLUSTERS

Women's Health (Obstetrics) Cluster Size: 403 • $14 345 average cost per patient • 98% Female • 94% between ages 20-44 • 0% end of life • 85% Obstetrical Diagnosis • 14% Depression • 10% Diabetes • 9% Obese	**Mental Health / Substance / Chronic** Cluster Size: 1752 • $33 016 average cost per patient • 59% Male • 75% between ages 45-64 • 4.2% end of life • 40% Depression • 19% Bipolar • 21% Alcohol / 20% Drug • 35% Acute Joint • 19% COPD	**Mental Health / Substance** Cluster Size: 584 • $31 271 average cost per patient • 57% Male • 88% between ages 20-44 • 0.8% end of life • 40% Depression • 16% Schizophrenia • 20% Alcohol / 27% Drug • 23% Conduct Disorder
Acute and Developmental Cluster Size: 149 • $20 091 average cost per patient • 60% Male • 66% between ages 5-14 • 0.7% end of life • 47% respiratory infections • 22% Attention Deficit • 20% Developmental Disorders • 11% Asthma	**Infant Complex** Cluster Size: 131 • $55 579 average cost per patient • 56% Male • 89% less than 1 year old • 3% end of life • 72% acute neonatal • 33% Low birth weight • 12% Chronic Cardiovascular • 5% Surgical Complication	**Elderly Chronic** Cluster Size: 1604 • $44 099 average cost per patient • 50% Female • 56% over 75 • 17% end of life • 31% Diabetes • 30% COPD • 21% CHF • 18% Alzheimer/dementia

Service models to be developed based on highest areas of opportunity



	Population	Avg Cost	Total Cost
Elderly Chronic	1604	44,099	$70,734,859
Infant/Complex	131	55,579	$7,280,858
Acute & Developmental (Children)	149	20,091	$2,993,494
Addictions/ Mental Health (Young Adult)	584	31,271	$18,262,417
Mental Health/Chronic (Older Adult)	1752	33,016	$57,844,682
Women's Health (Obs/Gyne)	403	14,345	$5,780,925

Marcus' story – the future

After a number of home visits from the outreach team, Marcus has now joined a Family Care Clinic and has a primary health care team that is teaching him how make to decisions to manage his chronic illnesses. His dietician, mental health worker and family physician are readily accessible at his local Family Care Clinic. He has decreased his use of the emergency department and has actually eliminated his inpatient admissions in the last six months. His primary care team monitors Marcus' health with him and are available to answer questions and make changes to his medications or add resources to help him manage his health and well being. Catching changes in Marcus' status early before they become more severe has made a drastic change in his life. He has access to specialists as needed and health providers can access his health records electronically.

The care team also linked Marcus and his family to some of the broader social supports that are available in his community. Marcus is now able to keep a job as his attendance has improved significantly. His mental health is improving due to his connections at the clinic and his increased self-esteem with regular work and pay. His wife and children are happier as dad can now take part in their activities as he is better able to manage his chronic conditions and overall health.

The system is supporting Marcus and his family much more effectively.

Comments?

Questions?

Thank you!