

# Alberta Health Services

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How a large  
integrated health  
system can improve  
continuity,  
collaboration and  
health gain



# Milestones

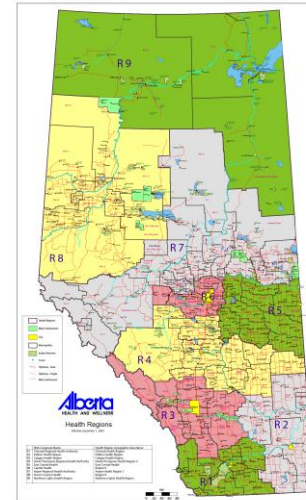
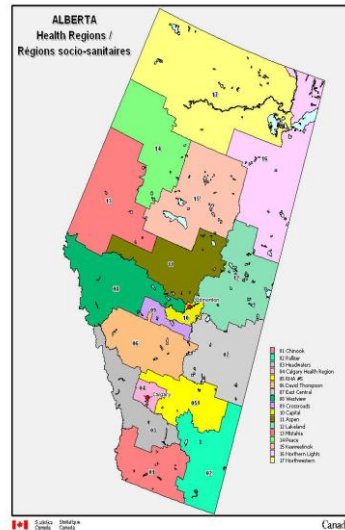
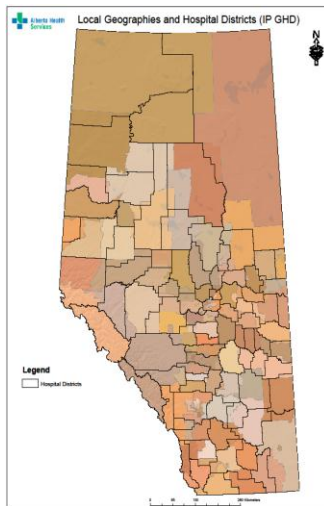
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- 1994: 17 health regions - appointed boards
- 2001: 17 regions - 2/3 board members elected, 1/3 appointed
- 2003: 9 regions – appointed boards
- 2008: 1 Provincial Board (replacing 9 RHAs, Alberta Mental Health Board, Alberta Cancer Board, and Alberta Alcohol & Drug Abuse Commission)

# An evolving map

1993

2008



# AHS Merger

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- Largest merger in Canadian history
- 12 HR/Finance/IT Systems
- Largest employer in AB; 5<sup>th</sup> largest in Canada
- Over 90,000 staff working with 10,000 physicians
- 102 Acute care hospitals
- 6,800 Acute care hospital beds
- 18,000 Long-term care & supportive living beds
- 7 Urgent care centres

# Pre-integration

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## Challenges

- Regional autonomy and variability -inequity
- Challenges with access
- Inability to achieve economies of scale

## Strengths

- “Local solutions to local problems”
- Regional innovation & benefits of competition

# Benefits of integration

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- Economies of scale- cost savings
- Economies of expertise- creation of provincial specialist roles
- New clinical structures to facilitate a provincial approach to access & quality
- Intraprovincial equity of access
- Improved intraprovincial learning & flow of best practices
- Integration

# Focus on clinical innovation

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- Clinical Networks
- Integrated Chronic Disease Program
- Primary Care Networks
- Geographic planning

# Clinical Networks

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## Goals-

- Improving patient outcomes and access
- Improving clinical practices
- Addressing quality and patient safety issues
- Applying clinical expertise to strategic and service planning
- Supporting teaching and research in Alberta Health Services.

# Clinical Networks

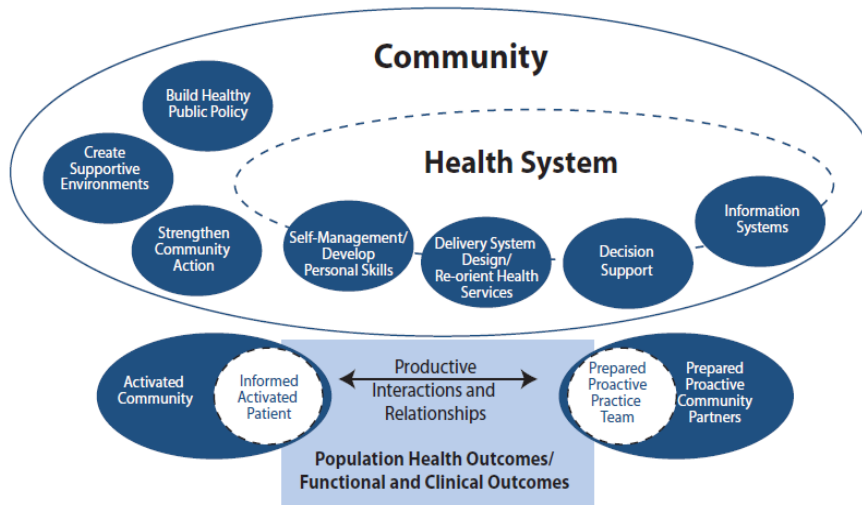
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- Cardiac
- Pulmonary
- Stroke
- Cancer
- Mental Health
- Bone and Joint
- Surgery
- Emergency
- ICU/Critical Care



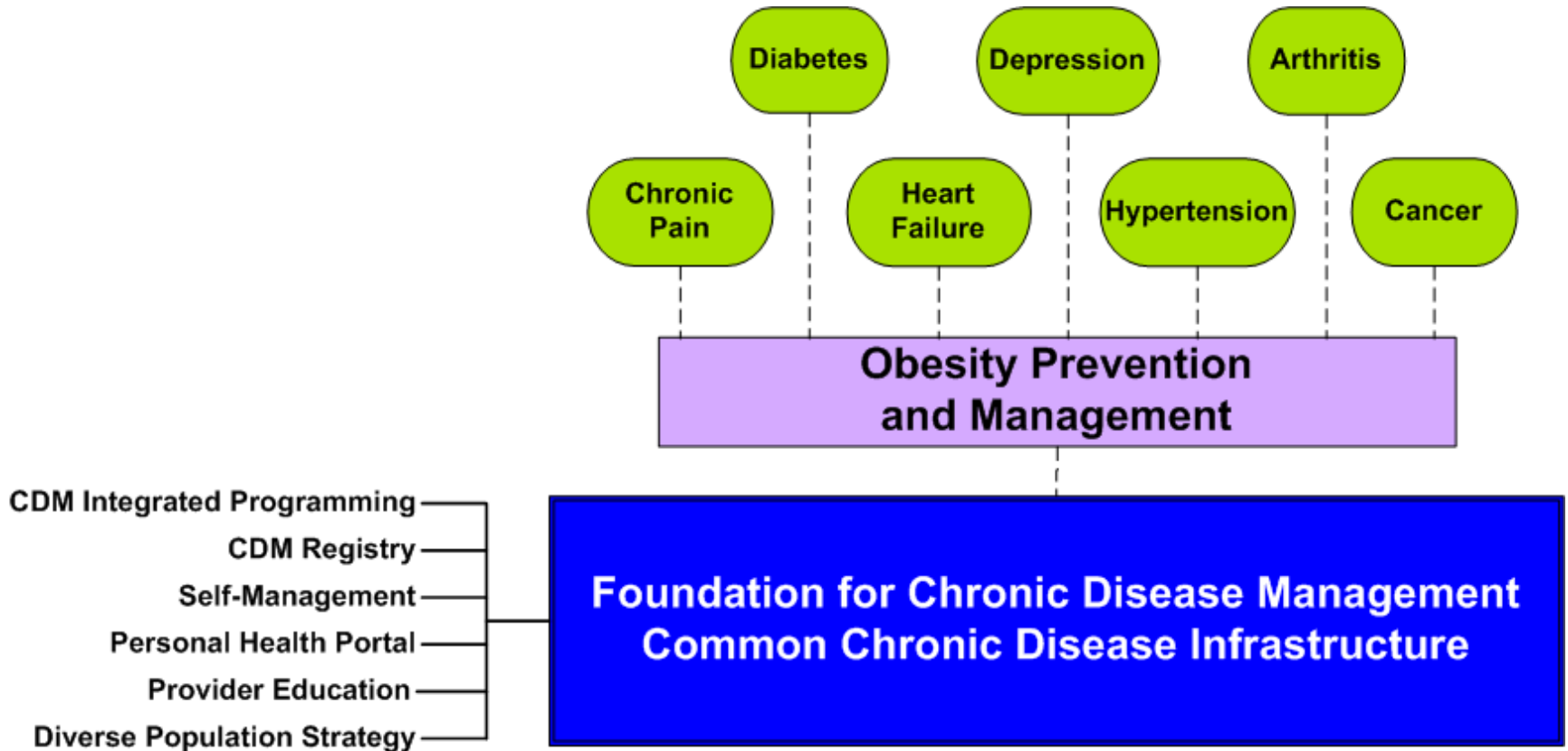
# Integrated Chronic Disease Program

The Expanded Chronic Care Model <sup>6</sup>



- Provider Education
- Self Management
- Diverse populations
- Integrated Community Programs
- Integrated Continuity of Care Record
- Personal Health Portal
- System wide self management

## Building the Foundation for Optimal Chronic Disease Management



Primary Care Model

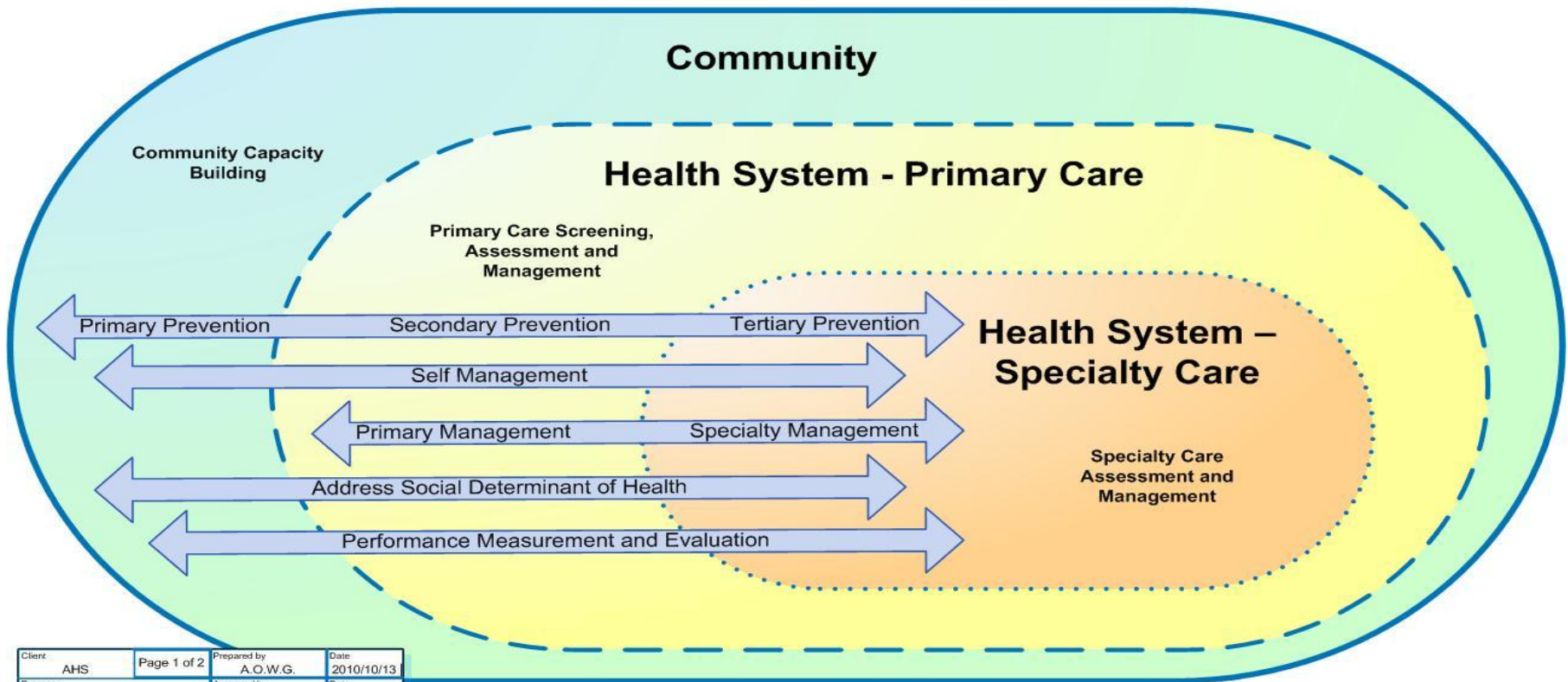
# Provincial Obesity Program

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- Addressing **prevention** with evidence-based policy development / implementation
- Building capacity in **primary care** to prevent / manage obesity and its resulting co-morbidities
- Expanding **specialty care** services to provide more equitable access for complex obesity management
- Builds on to a **common CDM infrastructure** that will be an important foundation for the prevention and management of other chronic diseases

# Program Pathway for Coordinating Care

## Draft Provincial Obesity Program Pathway - Adult



Client AHS	Page 1 of 2	Prepared by A.O.W.G.	Date 2010/10/13
Process Prov. Adult Service Model		Approved by	Date

# Primary Care Networks

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- Increase number of Albertans with access to primary care services
- Manage 24/7 access to appropriate care
- Increase emphasis on:
  - Health promotion and disease and injury prevention
  - Care of patients with chronic disease, complex health problems
- Better coordination and integration between components of the health system
- Greater use of multi-disciplinary teams

# Primary Care Networks

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- First PCN started in spring 2005
- 33 PCNs in operation, 10 more in development
- Over 2,000 family physicians involved
- Represents over 70 % of PCN-eligible family physicians in Alberta
- More than 355 FTE other health providers currently working in PCNs
- Over 2.2 million Albertans informally enrolled - 66 per cent of the province

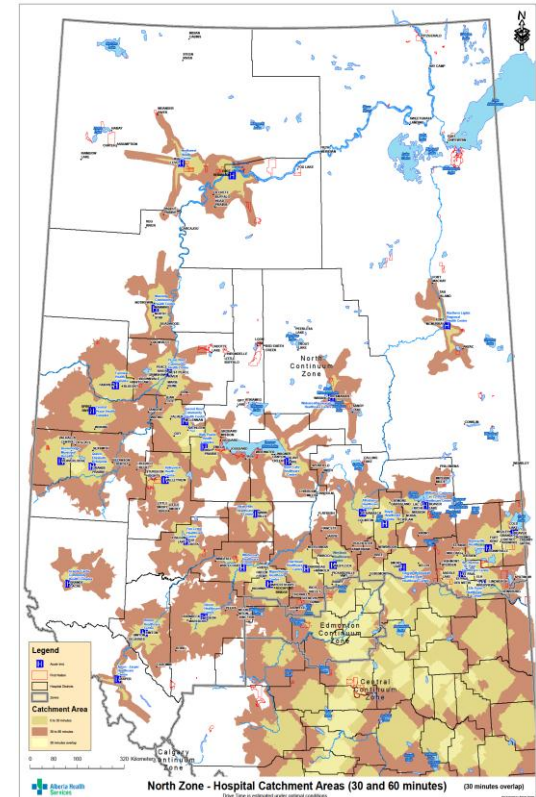
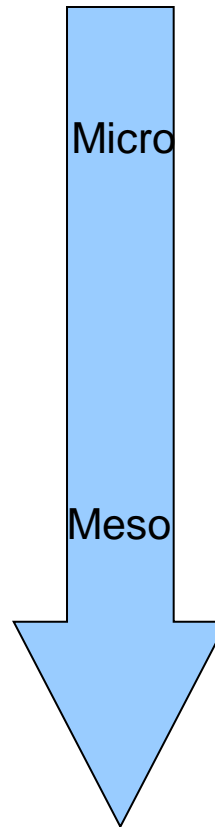
# Primary Care Networks: Results

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- Attachment to a primary care physician
- Access to in-hours care
- Availability of after-hours care
- Emergency Department Utilization
- Screening
- Health Promotion and Prevention Programming
- Care for Chronic Disease/Complex Patients
- Multidisciplinary teams

# Geographic Service Planning

- PCN Utilization Data pilot
- PCN Business Planning
- Community Assessment and Service Response
- Zone Integrated Plans



# Thank you!

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