Cardiovascular Health and Stroke Strategic Clinical Network

Accelerating Primary Care
November 23, 2014

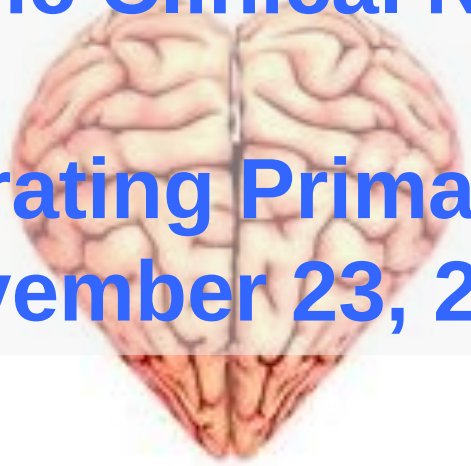

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EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Why?

- Primary Care as health care portal and funder
- Clinical Networks
- Successful Pilots rapidly operationalized

What are Strategic Clinical Networks In AHS?

- Engines of clinical innovation
- Focused on a population
- Collaborative clinical teams with a provincial strategic mandate
- Led by clinicians, driven by clinical needs, based on best evidence
- Comprised of an all-inclusive membership, with core members & clinical leadership

Strategic Priorities for CVH & Stroke SCN

Strategy 1: Enhanced Prevention

- Vascular risk reduction

Strategy 2: Quality Management

- Performance metrics; system measurement

Strategy 3: Reducing Inequities

- Urban / non-urban variance – rural stroke action plan
- Vulnerable populations

Strategy 4: Appropriateness & Sustainability

- Reassessment/ Appropriate Use Criteria (chest pain pathway with diagnostic modality algorithm)
- Clinical practice guidelines/shared best practices (CHF pathway; ACS-NSTEMI order set; CVS transfusion)

Role of Specialty SCN's

- Better integration of care across the continuum with support of PCN's as medical home
- Safer Care
- Reduce unjustifiable clinical practice variation and unnecessary testing and care
- Innovate better ways to deliver best practices
- Research
- Scale and spread best practices across Alberta

Key Enablers of Success for all SCN's

- Better alignment with Zone priorities
- Better integration and synergy with Provincial Programs
- Better engagement of physicians and AMA
- Better engagement of front line health care workers and middle managers
- Better utilization with IT, DIMR, and Quality

Vascular Risk Reduction

Why do this now – the numbers?

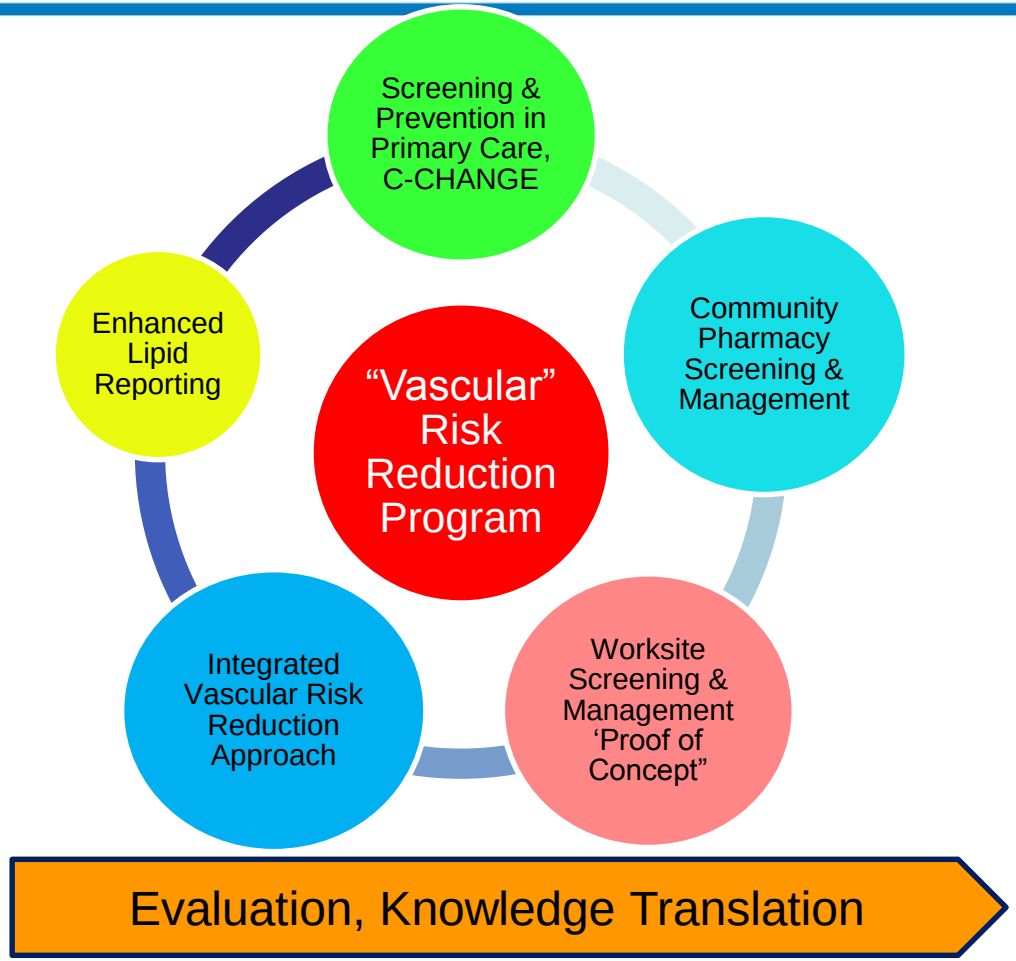
$373,025,231/yr	=	the economic burden of vascular disease in AB (heart diseases, high blood pressure, stroke)
> 3 million	=	# of Albertans with ≥ 1 vascular risk factor
> 1 million	=	# of Albertans with undiagnosed or under-treated high blood pressure
24%	=	Percentage of population who would benefit from lipid lowering therapy to reduce their risk of vascular disease (less than half currently on medication)

Will increase with aging population and growth

Care gaps need to be addressed

Can we afford not to do this now?

Vascular Risk Reduction Program

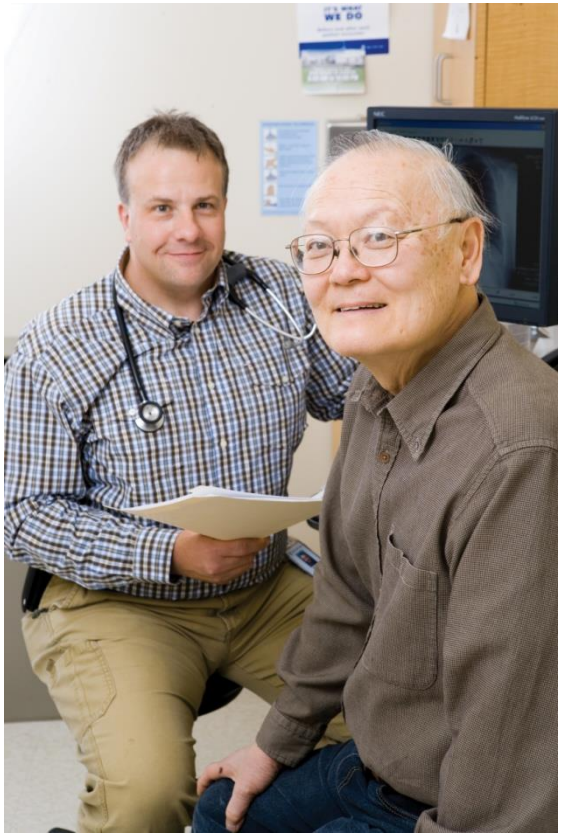


Description

What is the goal?	Short term – Reduce vascular risk of Albertans by identifying and managing risk that is undiagnosed and risk that is diagnosed but not well managed Long term - Reduce vascular disease (and chronic disease) death and disability in Alberta
How will we achieve this goal?	A series of projects in an integrated program of vascular risk reduction
Who will do this work?	CvS, ODN, Ca & AMH SCNs Alberta Health, TOP, U of C, U of A, partner organizations Collaborative Committee & 6 Working Groups

Vascular diseases –heart disease, stroke, peripheral arterial disease, diabetes and kidney disease
Vascular risk – hypertension, dyslipidemia, smoking, obesity, physical inactivity, unhealthy eating, harmful use of alcohol = Shared risk factors with most chronic diseases

Screening & Prevention: Primary Care



- Implementation of **C-CHANGE** in primary care
- **ASaP:** Alberta Screening and Prevention
- **Toward Optimized Practice** – project secretariat; supported by Alberta Health
- Implement effective **case-finding** processes and evidence-based management of vascular risk factors – opportunistic and outreach activities
- **Practice facilitation** – train-the-trainer model (70 trained)
- **Tools** (panel tracking, EMR)
- **Menu** of screening and prevention manoeuvres
- Target is to reach 2000 primary care providers (24 PC organizations enrolled)
- Knowledge Translation (CFPA and PLP)

Screening Maneuvers Menu for Adults

Alberta Screening & Prevention Initiative (ASaP)

Maneuver	Age (years)		General Population Interval
Blood Pressure	18+		Annual
Weight	18+		Annual
Height	18+		At least once
Exercise Assessment	18+		Annual
Tobacco Use Assessment	18+		Annual
Alcohol Use Assessment	18+		Annual
Influenza Vaccination/ Screen	18+		Annual
Pap Test	Females 21 – 69		3 years
Plasma Lipid Profile - Fasting	Males 40 – 74	Females 50 – 74	3 years
CV Risk Calculation	Males 40 – 74	Females 50 – 74	3 years
Diabetes Screen One of: - Fasting Glucose - Hgb A1c - Diabetes Risk Calculator	40+		3 years
Colorectal Cancer Screen One of: - FOBT/FIT - Flex Sigmoidoscopy - Colonoscopy	50 – 74		2 years 5 years 10 years
Mammography	Females 50 - 69 (74)		2 years

Screening & Management: Pharmacy

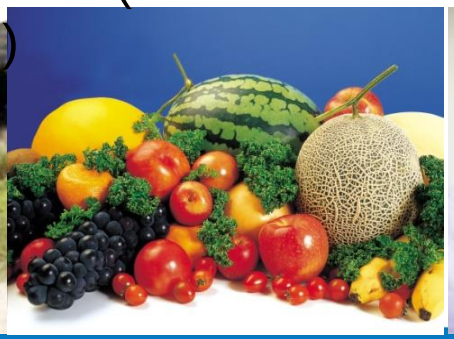
- Develop and implement a **community pharmacist-initiated vascular risk reduction** case-finding and intervention program based on the C-CHANGE guidelines
- Includes screening, case-finding and pharmacist-initiated management
- **Work with local primary care providers** to ensure care is integrated
- **Target** includes vulnerable populations
- Assess for impact on vascular risk
- 112 pharmacists (78 pharmacies)
- Target is >1100 patients

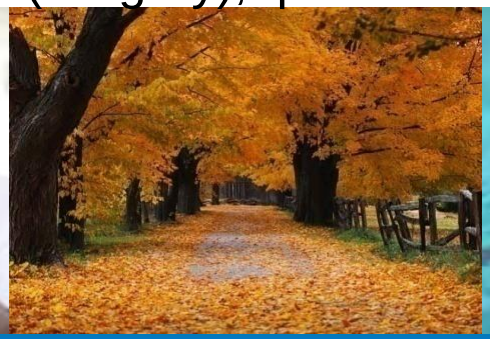
Screening & Management: Worksite (pilot)

- Pilot an intervention designed to **optimize the cardiovascular risk profiles of workers** with at least one uncontrolled risk factor (hypertension, dyslipidemia, smoking)
- Partnership with SunLife and Nexen
- Goes beyond screening and ‘wellness’ programs’
- **Includes case management (NP**) and both non-pharmacological and pharmacological therapies
- Assess for impact on vascular risk

Integrated VRR Approach

- Atheromatous disease is often found in more than one arterial bed
- Commonalities in management strategies
- Opportunity to **integrate VRR** to reduce the risk of future vascular events more effectively while **eliminating redundancies**, promoting system efficiencies and being more patient-centric (as opposed to current siloed approach)
- **Environmental scan** to assess current state and identify opportunities for integration
- **Pilot integrated model in 3 sites in Alberta**. Small Urban (Medicine Hat), Rural (Slave Lake FCC), Urban (Calgary), possible 4th (Grand Prairie)




Enhanced Lipid Reporting

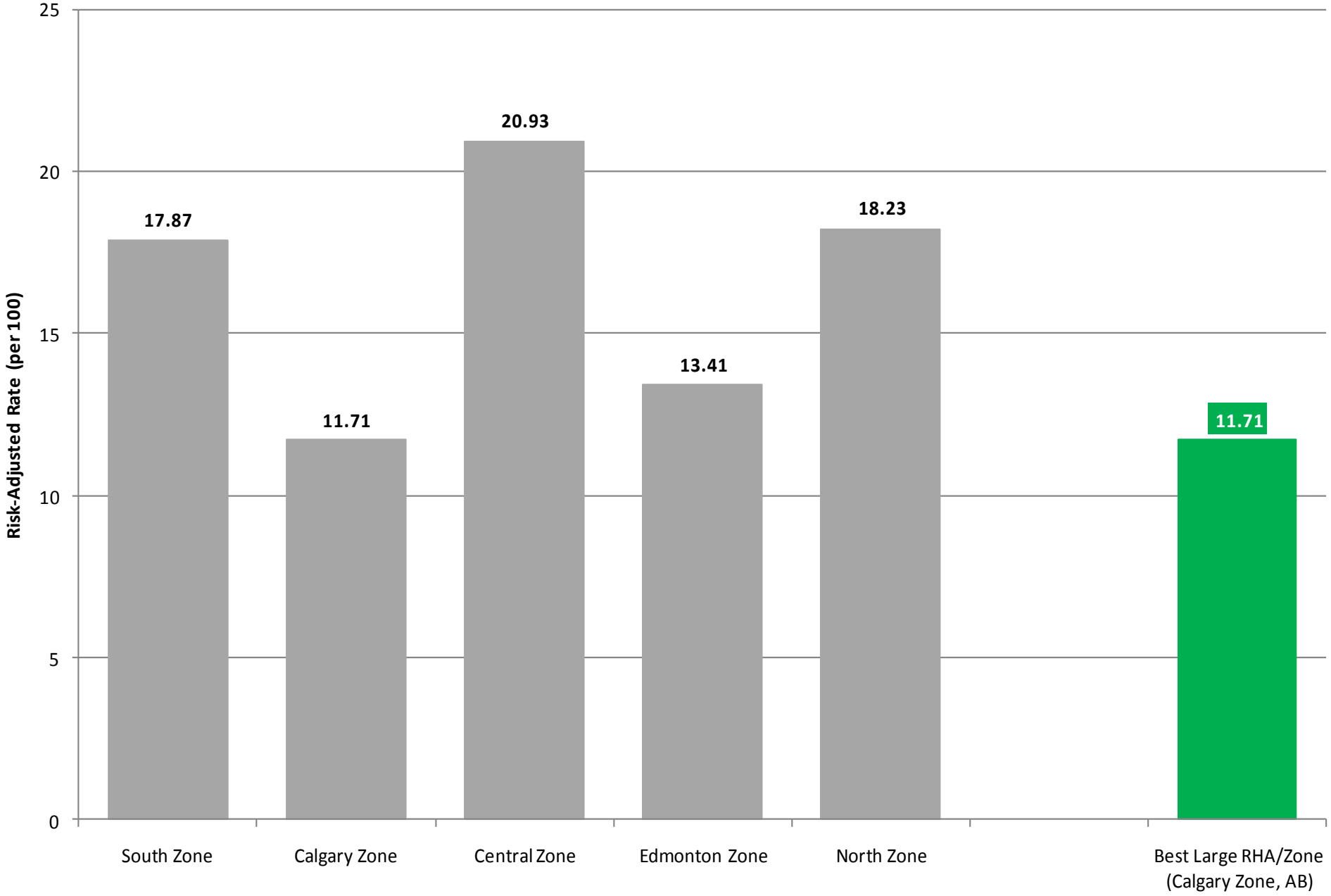
- Identify patients suitable for lipid-lowering treatment and promote shared decision making
- A **laboratory-based solution for determination and reporting of CV risk**
- Demonstration project in one Primary Care Network (Chinook) to assess:
  - Feasibility
  - Change in use of lipid lowering therapy
  - Change in lipid profile testing
- Rapid provincial scale up & roll out

What will success look like?

Short term: Improved detection & management of risk factors

Long term: Reduced vascular morbidity and mortality (and other chronic diseases)

30-Day In-Hospital Mortality Following Stroke - 2010/11



Source = CIHI CHRP

The Opportunity

- ***Care often falls short of its theoretical potential***
  - Well documented massive variation in practices
  - High rates of inappropriate care
  - Unacceptable rates of preventable care-related patient injury and death (errors of commission)
  - A striking inability to do *"what we know works" (errors of omission)*
  - Huge amounts of waste leading to spiraling costs that limits access to care – 50% of resource expenditures in hospitals is quality-associated "waste"

Learning Collaborative Approach to Improving Outcomes

- Build evidence-based best practice protocols
- Incorporate them into clinical workflow
- Embed data systems to track protocol variations and short- and long- term results
- Expect that clinicians vary care based upon patient need
- Feed the data back in a “Learning Loop”
- Consistently update and improve protocols

The Stroke Action Plan

Objectives

- Reduce death and disability from stroke
- Produce a cost avoidance for Alberta
- Improve the quality of and access to stroke care
  - enhancing stroke unit level care in small urban and rural centres
  - implementing early supported discharge and community rehabilitation services in small urban centres

What is a stroke unit?

- Geographically clustered set of beds within a hospital
- Staff/physician specialization and training in stroke
- Integrated care - multidisciplinary assessment/ communication
- Early access to rehabilitation services
- Involvement of caregivers, family, and patients in the process of care delivery
- Adherence to best medical practices in stroke care

Why stroke units?

Benefits:

- Associated with a 15% relative reduction in death and a 5% relative reduction in disability for patients with stroke from multinational randomized trials
- 20% reduction in length of stay

The Quality of Stroke Care in Canada, CSN, 2011

Sites

ESD & SUEC

- Camrose
- Red Deer
- Grande Prairie
- Lethbridge
- Medicine Hat

SUEC Only

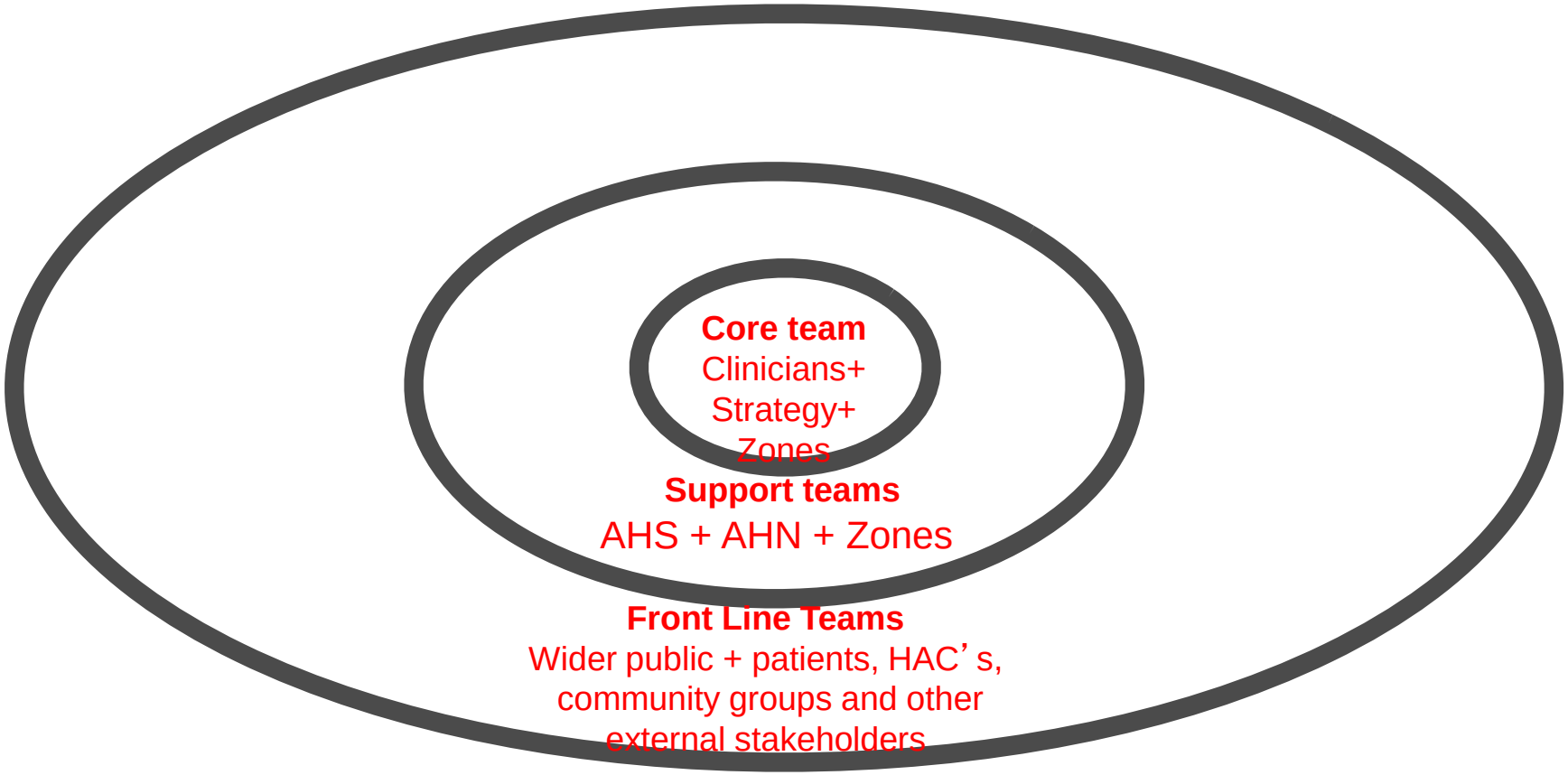
- Barrhead
- Fort McMurray
- Peace River
- Hinton
- Westlock
- Cold Lake
- Lloydminster
- Wainwright
- Brooks

Other SCN Work of interest to Family Practitioners

- Working with AMA on “Achieving System Wide Efficiencies” and Choosing Wisely Canada
- PRIHS grant- Best long term monitoring for a fib for stroke risk
- Cardiac Imaging Pathway Development
- Heart Failure Optimization – Transition of care back to medical home

SCNs are “all in” – broad perspectives needed

particularly primary care perspective



Alberta Health Services

QUESTIONS

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