Recovery From Addiction

STRATEGIC CLINICAL NETWORKS: AN UPDATE

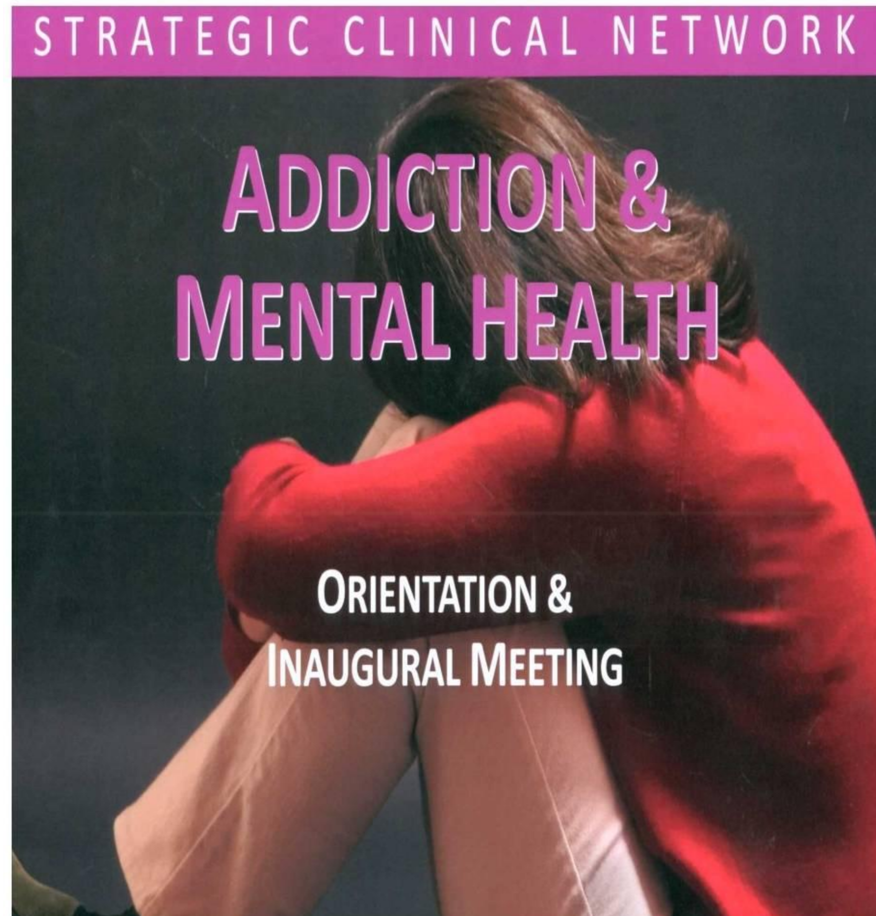
Cathy Pryce, RN MN
Vice President - Addiction and Mental Health
Strategic Clinical Network
Alberta Health Services

October 2012

Norlien Foundation

Alberta family wellness initiative

Welcome to A&MH SCN Orientation



The Landscape in 2012

Provinces to Drive Health Reform

Globe and Mail Headline – December 21, 2011

'This year marks the 50th anniversary of Medicare. Premiers want to create a new approach that provides better quality care while being sustainable.'

Premier Brad Wall

'We run 13 distinct health care operations now across this country and certain provinces are doing certain things better than others. We think there is a great opportunity for us to be able to collaborate together.'

Premier Robert Ghiz

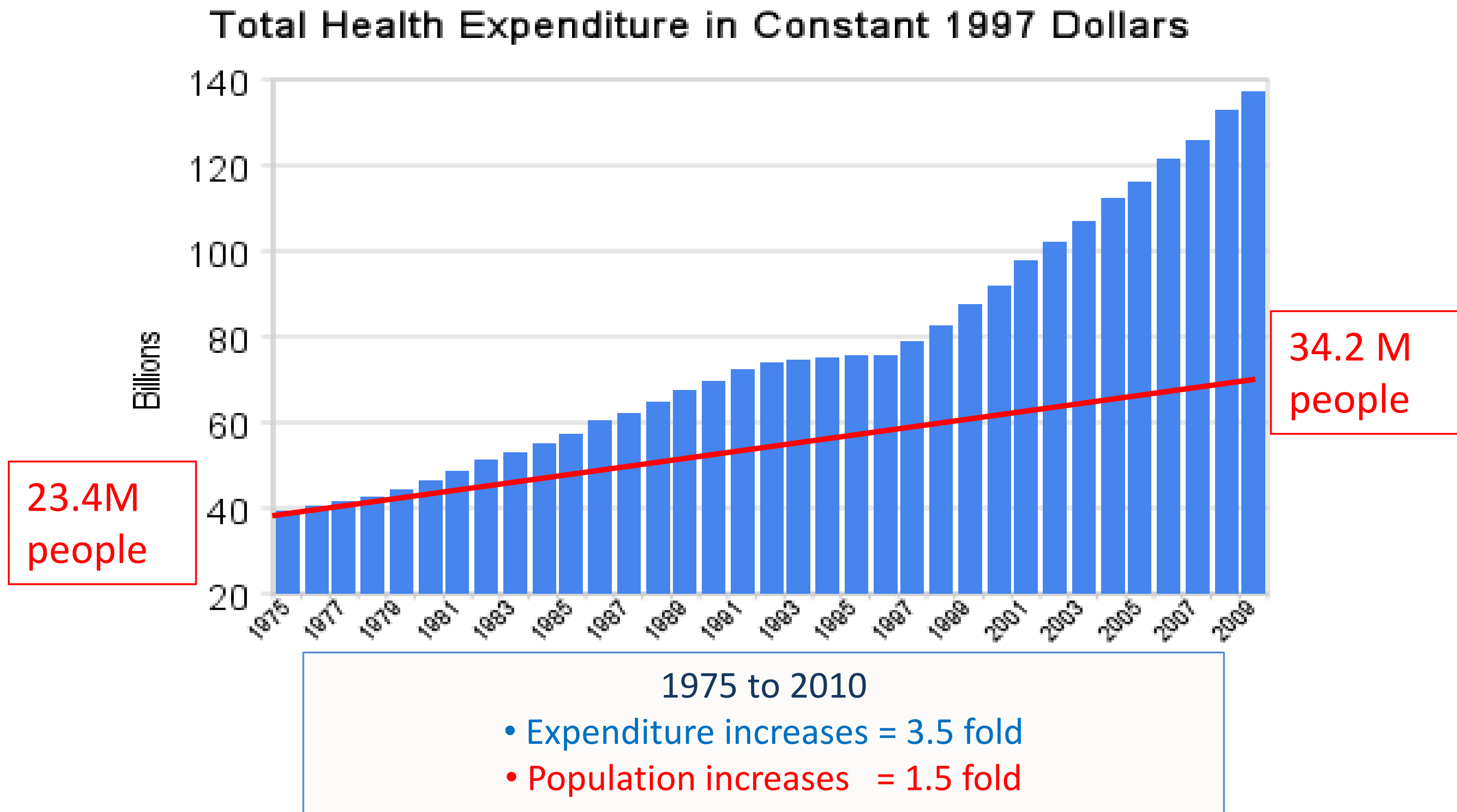
'It's a bold agenda. We need to not just innovate, but also be sure that we are sharing those innovations all across the country.'

Premier Christy Clark

Changes are needed

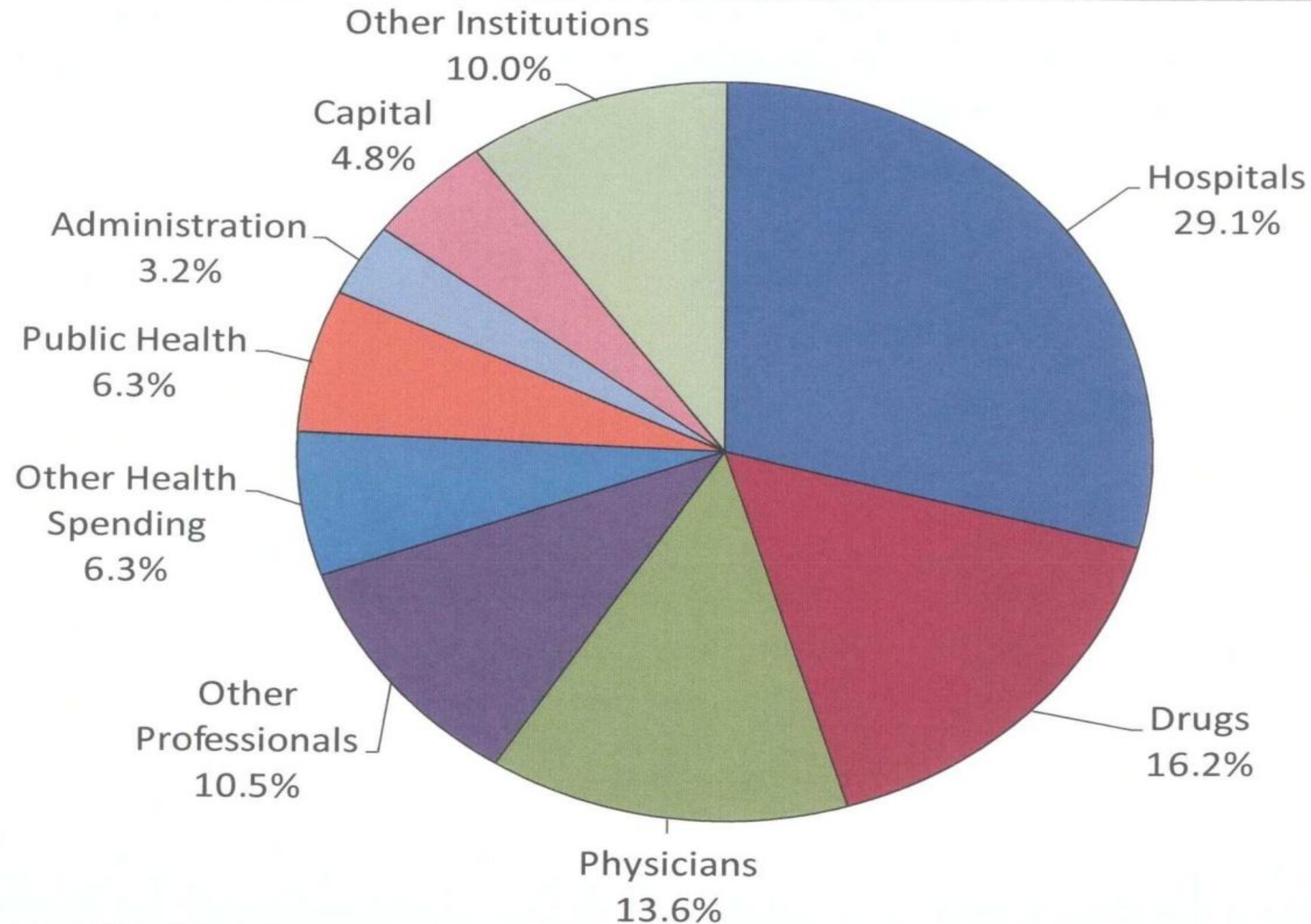
Evidence = Non-sustainable healthcare cost increases in Canada

December 2011: Alberta is 2nd highest (not getting value for $$)



Why are we here? How do we compare?

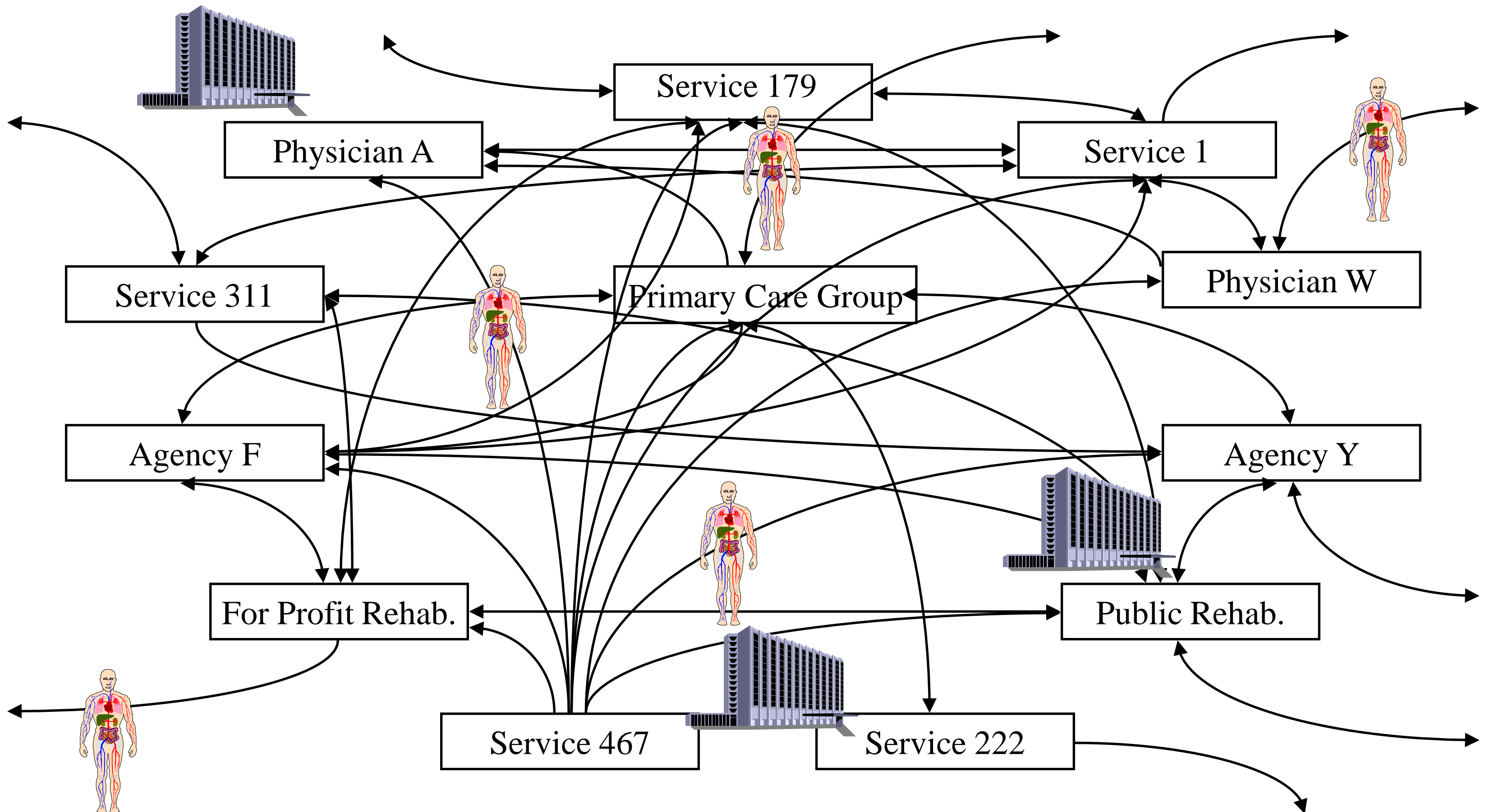
What are we spending it on? CIHI Data - 2009



What are Root Causes?

and what can we do about them without compromising care, and in fact, while <u>improving</u> quality of care

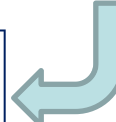
As more is learned – the complexity of care increases (driving waste + inefficiency)



Our Line of Sight

3.1 Strategic Directions

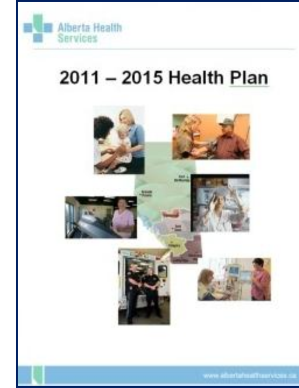
3.2 Strategies



1. Our system plan

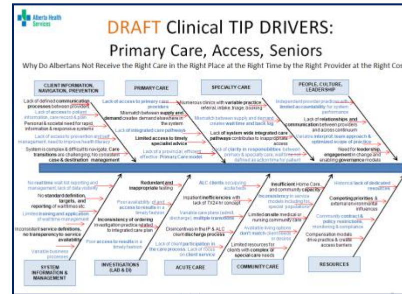
2. Targets

4. How AHS will achieve

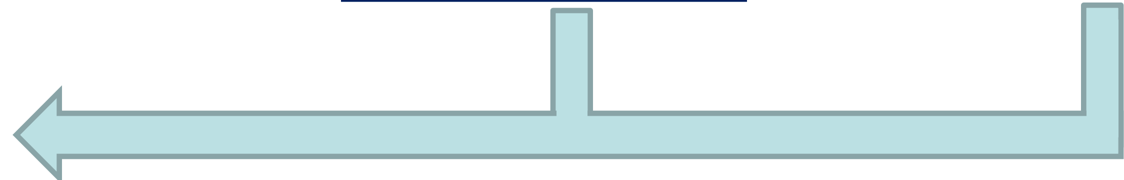


5.1 Vehicles

5.2 Accountability



6. Performance Measures & Risks

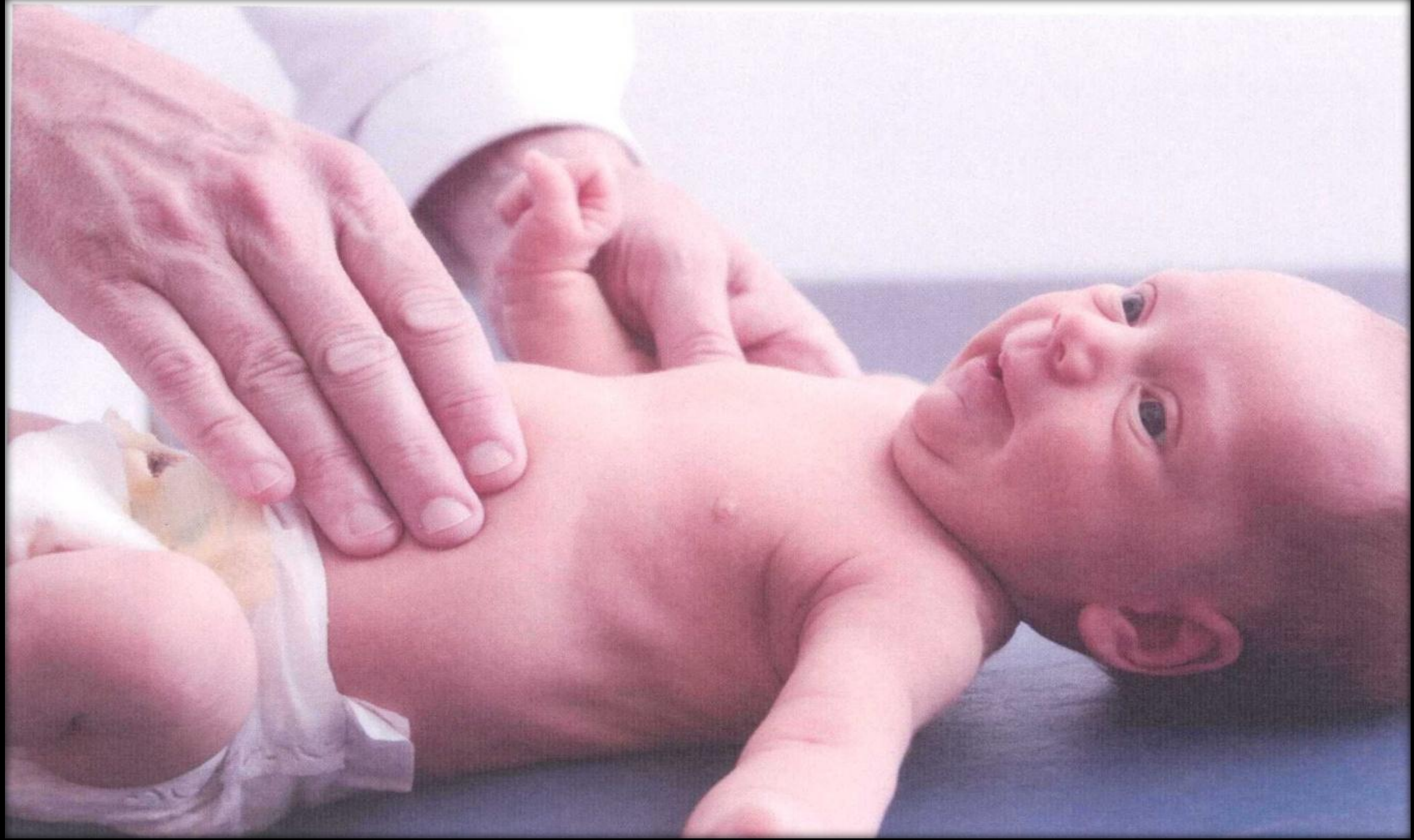


STRATEGIES to ELIMINATE these ROOT CAUSES

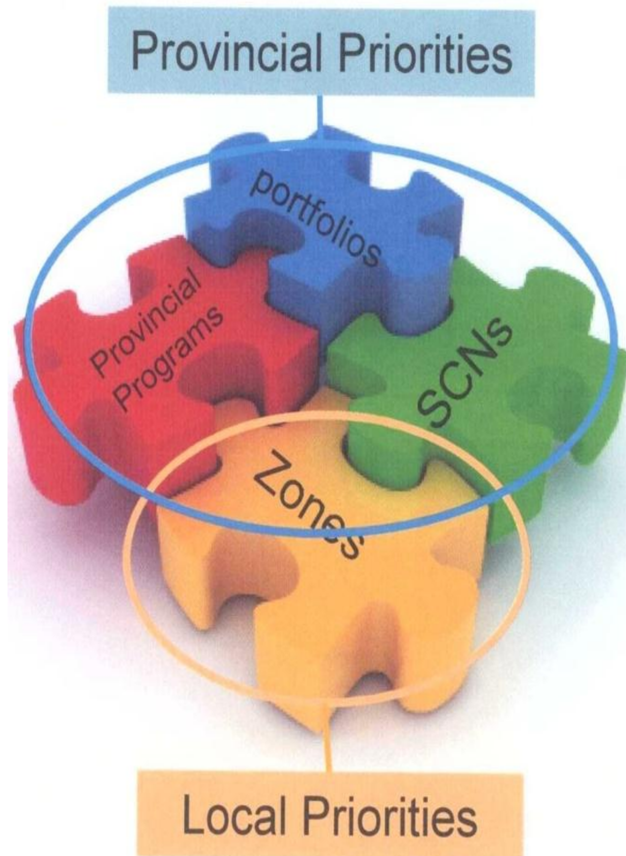
Top 20 characteristics of ‘high performing health systems’

1. **Success is defined and terminology is clear for all stakeholders. Quality is defined.**
2. **Physicians are engaged at all levels.**
3. **‘Innovation’ is defined and embraced: people, processes, and systems. Not just devices/drugs.**
4. **People in teams and networks - that lead a culture of innovation across boundaries (people, processes, systems, services).**
5. **People test innovation; it’s OK to fail.**
6. **Champions of change (and leaders) are identified, developed and supported.**
7. **There is an engaged and empowered public (the public is actively involved).**
8. **Evidence-based treatments and approaches are used wherever possible and/or are pursued through research.**
9. **There is fusion of health, environment and education in a planned way: the health system addresses broader determinants.**
10. **The system improves value (and value for money) for all as a major goal.**
11. **Good information for decisions is essential: real time evidence is key.**
12. **Prevention is ‘part of doing business’ (it is somebody’s job).**
13. **The system invests to buy positive changes.**
14. **There is a good human resource system.**
15. **Careful (avoid perverse) incentives are used to incent all stakeholders.**
16. **Careful (avoid perverse) on-line measurement with feedback to those who need it. Measure for goals and beware of what is not measured.**
17. **Strong and engaged primary care and strong community care.**
18. **Planning models with embedded research.**
19. **Be patient but always keep the patient in mind. Meet or exceed patient expectations as a top priority.**
20. **‘Top down’ meets ‘bottom up’ in all ways (structures, programs, goals).**

The Mandate of SCN's



AHS should be >> sum of the parts



- Establish Common goals
  - Best Health
  - Best Health care
  - High performing system
- Establish Common Priorities
  - Best value for money
  - Eliminate Waste
  - Collaboration to achieve goals
  - Best business decisions

Use Lessons to Create Strategic Clinical Networks

Support to lead Provincial Improvement and Sustainability

Phase One (established June, 2012)

- Obesity, Diabetes and Nutrition
- Seniors' Health
- Bone and Joint
- Cardiovascular and Stroke
- Cancer
- Addiction and Mental health

Phase Two (Spring 2013)

- Population Health and Health Promotion
- Primary Care and Chronic Disease Management
- Maternal Health
- Newborn, Child and Youth Health
- Neurological Disease, ENT and Vision
- Complex Medicine (current Respiratory Clinical Network + others TBD)

SCN – a big business

Clinical Area	Inpatient Cost	ED + UC	Physician Services	Total
Addiction and Mental Health	$194,898,187	$11,499,681	$219,134,001	$425,531,869
Bone and Joint	$149,284,168	$21,615,954	$161,930,594	$332,830,715
Cancer	$116,225,723	$9,655,216	$68,344,711	$194,225,649
Cardiac and Stroke	$202,145,065	$21,811,328	$149,068,838	$373,025,231
Diabetes Nutrition Obesity	$37,766,695	$2,559,936	$63,247,102	$103,573,733
Seniors Health	TBD	TBD	TBD	TBD

SCN success and future investment by executive will be based on evidence of improvement in:

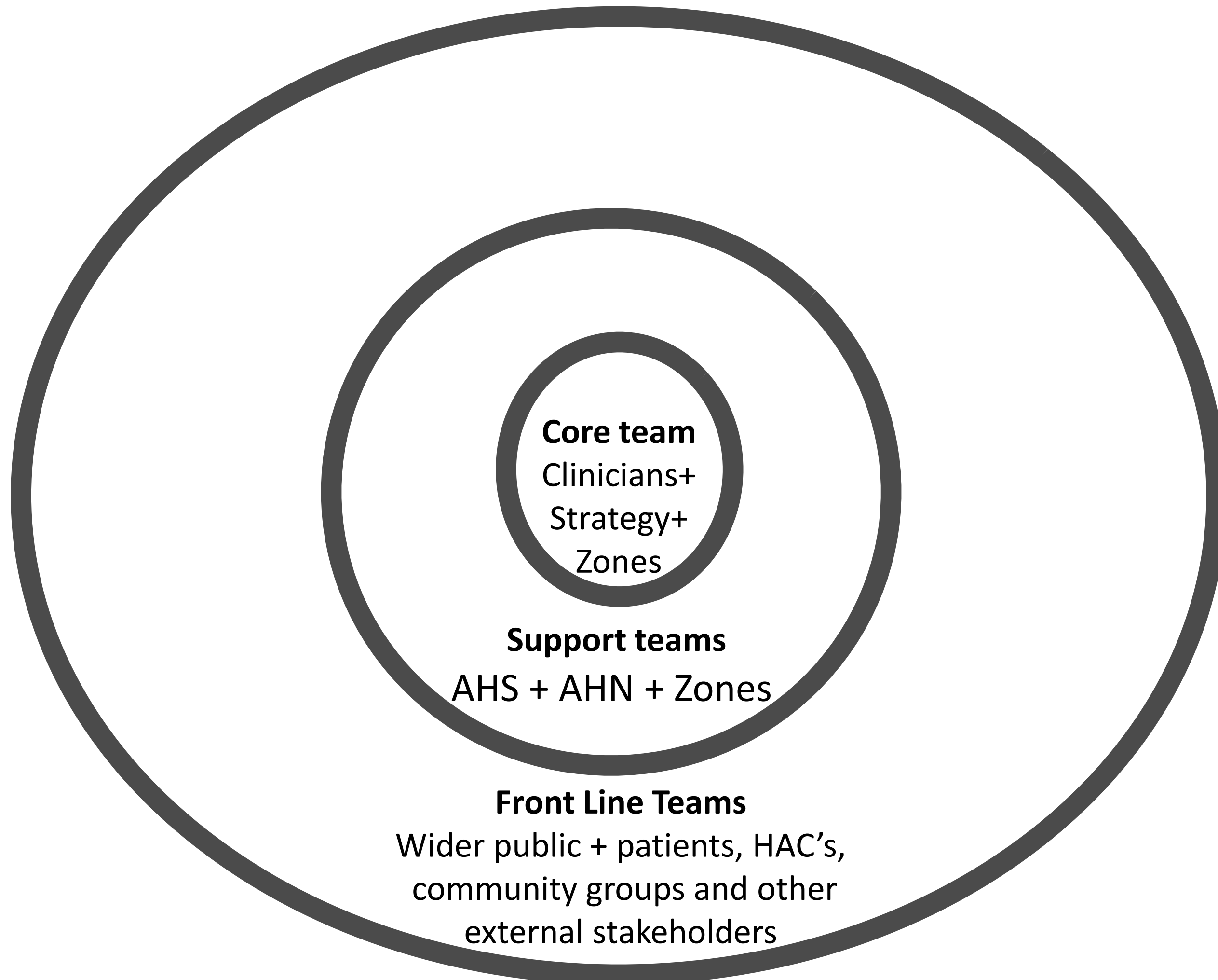
- Prevention of disease and proactively lessen specific burdens of illness in Alberta
- Patient outcomes (effectiveness)
- Patient accessibility and acceptability (patient satisfaction)
- Clinical practices, including appropriateness of care
- Efficiency and reduce provincial variation
- Patient safety
- Value for money and sustainability

13 SCN Functions

1. To improve value for money in AHS - with evidence
2. To support and, where applicable, lead population and public health initiatives – either as individual SCNs or a cross-cutting initiative of all
3. To develop evidence and best practice based care models and pathways for dissemination and implementation in AHS
4. Develop and publish measures and performance across quality dimensions
5. Assess and reassess technologies and enable evidence development,
6. Prioritize outcomes and interventions for improvement by zone and across the continuums of care
7. With zones and communities –undertake a medium and long term view of needs and service development to drive quality and sustainability.
8. Engage clinical experts, users, patients and members of the public to design service models and implementation strategies to achieve goals
9. With zones implement, evaluate and optimize innovative service delivery models
10. Proactively develop and use research, generate new knowledge and apply knowledge translation skills within the Academic Health Network (AHN) to solve clinical problems of importance over time
11. Proactively indentify innovations and, where applicable, with AHN and government partners, initiate commercialization processes
12. Determine best use and allocation of available resources
13. Develop outcome improvement agreements zones including the commitment of resources on key new interventions, as well as change management as required.

The SCNs are "all in" – broad perspectives needed

to achieve the balance in access – quality - cost



Core Team Members

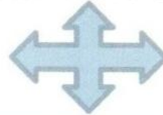
SCN Member	Role on SCN Committee
Dr. Michael Trew	Senior Medical Director
Cathy Pryce	Vice President
Marni Bercov	Executive Director - SCN
Susan Rawlings	Clinical Network Officer Project Coordinator
TBD	Scientific Director
Dr. Bev Adams	Department Head for Psychiatry - Calgary
Dr. Hugh Colohan	Psychiatrist with addiction focus
Dr. Allan Donsky	Paediatric Psychiatrist
Tuxephoni Winsor	Nurse with addiction focus
Dr. Doug Urness	Psychiatrist with community focus
Heather Toporowski	Zone VP Lead
Dr. Glen Baker	Department Head for Psychiatry - Edmonton
Dr. Judy Ustina	AMA Psychiatrist
Katherine Hay	Occupational Therapist with mental health focus
Kerry Bales	ZEL Senior Leadership
Tom Shand	Strategic Partners: Alberta Alliance on Mental Illness and Mental Health
Nancy Reynolds	Strategic Partners: Science Policy Practice Network for Children's Mental Health
Dr. Geoffrey Tagg	Patient /family lead - A&MH Patient Advisory Council
Kaj Koravela	Patient /family Lead - A&MH Patient Advisory Council

SCN Member	Role on SCN Committee
Silvia Vajushi	Alberta Health Policy Lead
Dr. Sandra Corbett	Adult Psychiatrist
Susan Gloster	Zone ED Lead
Debbie Gray	Population Health
Dr. Terry Smith	Primary Care Physician with expertise in mental health
Marlys Reynar	Psychologist and frontline clinical director A&MH service
Cara Greene	Promotion and Prevention
Dr. Peter Davis	Primary Care Physician with connections to Shared Mental Health Care
Dr. Glenda MacQueen	U of C, psychiatrist, researcher
Laurie Beverley	Executive Director – A&MH Primary and Community Care
Kathy Huebert	Information, Knowledge Translation, Evaluation
Trevor Riehl	Project Managers
Haydon Dewes	Communications Director - Provincial Programs
Cathie Scott	Knowledge Management support
Michael McMorris	Health Economist/ Financial Analyst
Dr. Rod Elford	Health Link rep
Neil Brown	Director IT, Addiction & Mental Health Services

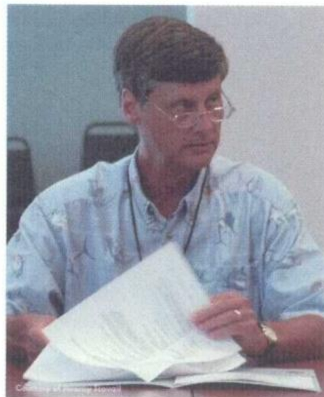
SCNs need to align 'top to bottom'

Sustainability requires balance of needs, perspectives and incentives

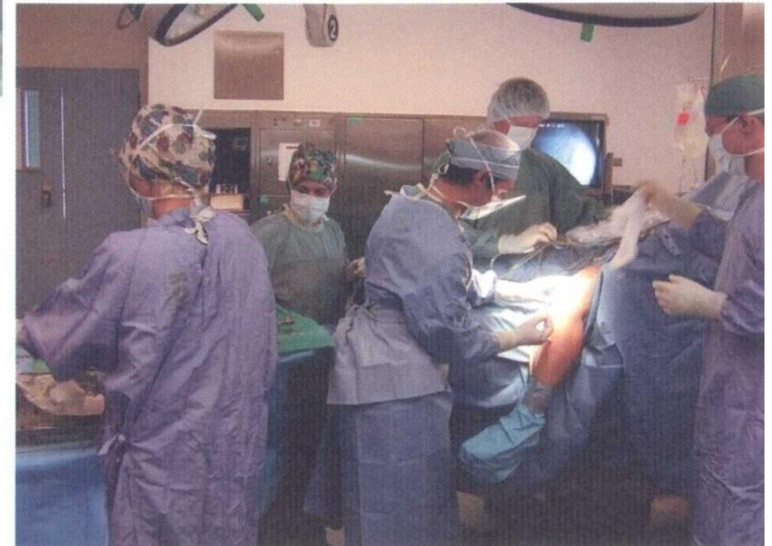
Administrators



Patients



Policy Makers/Payers



Providers

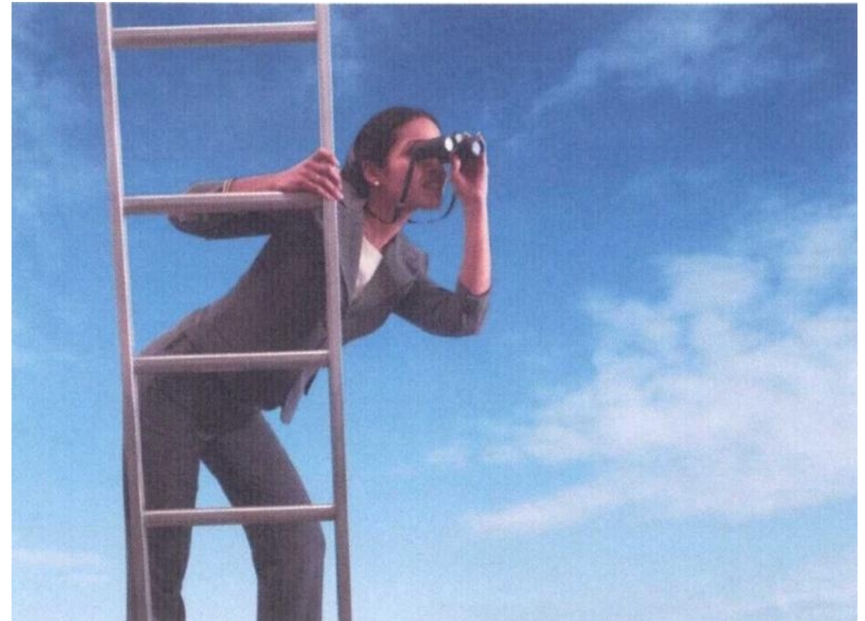
Identify the opportunities

Current Priorities

- Variation: appropriateness, efficiency, accessibility
- National benchmarks/indicators
- Key underserved populations or zones

Future Priorities

- Scenarios and Projections



Assessing Addiction and Mental Health Population Health Needs

The World Health Organization (WHO) has stated that

6 out of the 10 leading causes

of ‘years lived with disability’, in developed regions, are mental health diagnoses, and harmful use of alcohol is the third leading risk factor for disease & disability in high income countries

Murray CJL, Lopez AD. The global burden of disease
1996 Geneva WHO Ch.4 pp.201-246

Assessing Addiction and Mental Health Population Health Needs

- Alberta's population to increase by 37% by 2030. [1]
- Nearly 50% of the national population will meet diagnostic criteria for a mental health problem in their lifetime.
- Addiction is implicated in a wide variety of health, social and legal problems.
- 12% of Canadians have reported suffering from depression in their lifetime.[2]

1 Alberta Health and Wellness, Interactive Health Data Application, 2010 Population Projections, retrieved from http://www.ahw.gov.ab.ca/IHDA_Retrieval/

2 Kessler RC, Berglund PA, Demler O, Jin R, Walters EE: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Arch Gen Psychiatry 2005; 62:593–602.

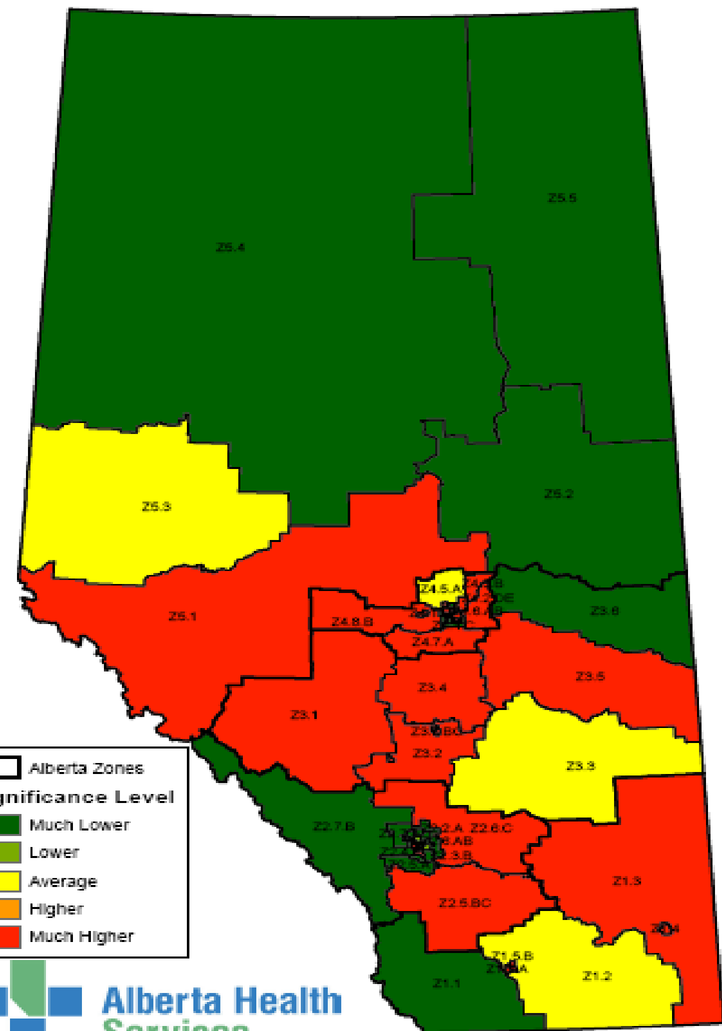
Assessing Addiction and Mental Health Population Health Needs

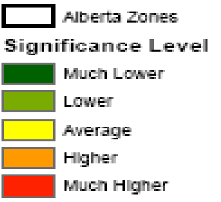
- *Alberta study* [1]
  - 3-year period,
  - **one in three** Albertans accessed a physician for mental health services. 899,236 Individuals
  - 3-year treated prevalence: 33%
    - anxiety disorders 16.4%
    - depression 11.8%.
  - Major trauma – 33.6% tested positive for alcohol

1 Slomp, Bland, et al. *Three-Year Physician Treated Prevalence Rate of Mental Disorders in Alberta.* Can J Psychiatry. 2009;54(3):199–202.

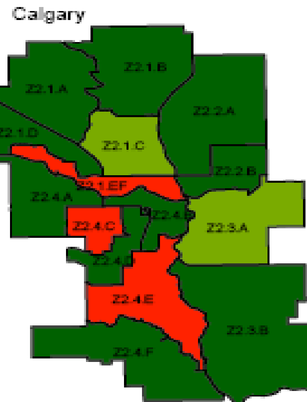
Assessing Addiction and Mental Health Population Health Needs

Depression (All ages) Age-Sex Standardized Treated Prevalence Maps by Significance Level per 100 Population for 09/10

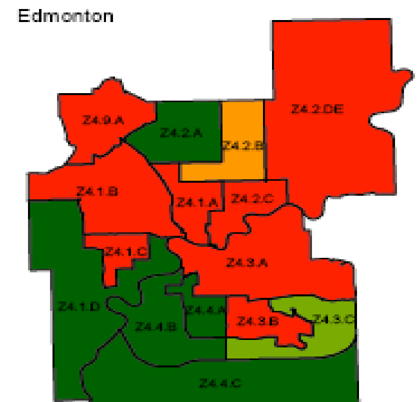




Calgary



Edmonton



Depression

Definition:
Depression is a state of low mood that can affect a person's thoughts, behaviours, feelings and physical well-being. Symptoms of depression can include feelings of sadness, anxiety, worthlessness, and irritability, withdrawal from friends/family, difficulty thinking clearly, thoughts of suicide, insomnia, among others. Depression can also have physical symptoms such as fatigue, stomach complaints and muscle/joint pain.

In this report, depression was defined as a hospitalization for a primary ICD-10 diagnosis of depression (F32 or F33) or two or more visits for depression with a primary care provider.

Significance of Depression:
Estimates of the lifetime prevalence of depression for Canadians are at least 12.2%, and 4.8% in the past year. In Alberta, approximately 200,000 people per year are treated for depression by a physician. Depression significantly impacts the lives of individuals and can be fatal. There is a strong association between depression and suicidal behaviour and suicide. Job performance, personal relationships and physical health can all be negatively affected by the disease. Depression can be treated with a variety of therapeutic interventions, including medication (antidepressants), talk-therapy ex: Cognitive Behavioural Therapy), self care and supported self management, to both improve symptoms and prevent re-occurring episodes. However, many people experiencing depression do not seek
or are unable to receive adequate treatment. Depression affects people differently and is not at all homogeneous in terms of its impact on individuals. The disability related to depression ranges from mild cases requiring little or no intervention other than "watchful waiting" to extremely severe and disabling cases where intensive, possibly long term treatment is required.
In Alberta, three year physician treated prevalence rates suggest that depression affects a considerable portion of the population:
- 3-year treated prevalence rate for individuals who accessed physicians for depression was 11.8%.
- Gender specific rates demonstrated that females had a higher three year treated prevalence rate: 15.6%;whereas the three year rate for males was 7.9%.

Burden of Disease:
Depression is the third greatest contributor to the overall burden of disease worldwide. In middle-to-high income countries, such as Canada, it is the single greatest contributor. Of the top 20 illnesses in Canada that contribute to the burden of disease, unipolar depressive disorders accounts for the highest amount of disability adjusted life years (409 DALY's per 100,000 population). The burden of disease for depressive disorders in Canada is almost 10 times higher than bipolar disorders and nearly double that of heart disease, the health condition with the second highest disability adjusted life years. Depression is also a greater contributor to the burden of disease for women, particularly young women, than for men.

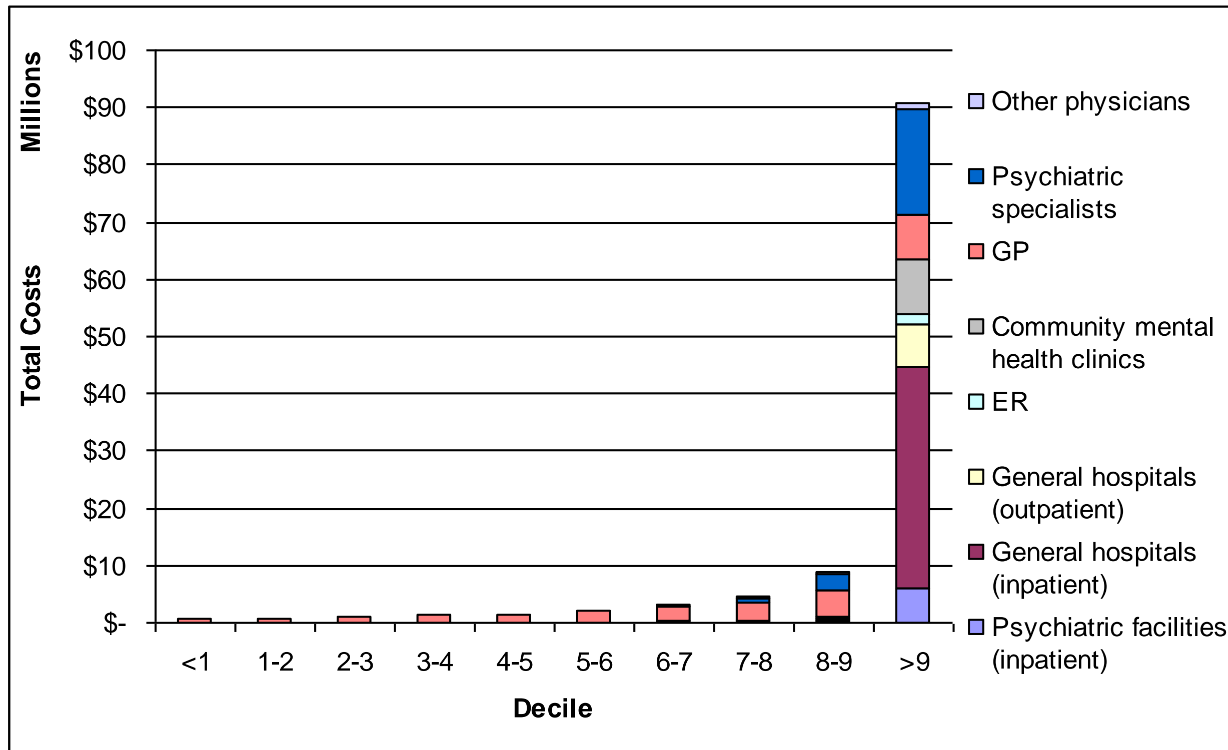
Data/Mapping Limitations:
1) Geographies with populations below 1,000 people will be excluded (masked) from both maps and prevalence graphs.
2) Treated prevalence may underreport true disease prevalence.
3) Treated prevalence calculations are based on CRG/EDC data from 02/03 to 09/10
4) Local screening initiatives and provision of service may result in higher reported treated prevalence and contribute to regional variability.
6) Other variable known to affect disease prevalence (e.g. Socioeconomic Status, Ethnicity) were not included in this analysis.
7) Data sets in the analysis include 1 - Provincial Inpatient Abstract Data 2 - Provincial Ambulatory Abstract Data 3 - Alberta Physician Claims Data
8) Alberta Health and Wellness (AHW) - Geographic Methodology Series No. 3, a rate mapping template 2004

1. Disease Template created in collaboration with Mel Slomp (Director, Knowledge and Strategy Addiction and Mental Health AHS)

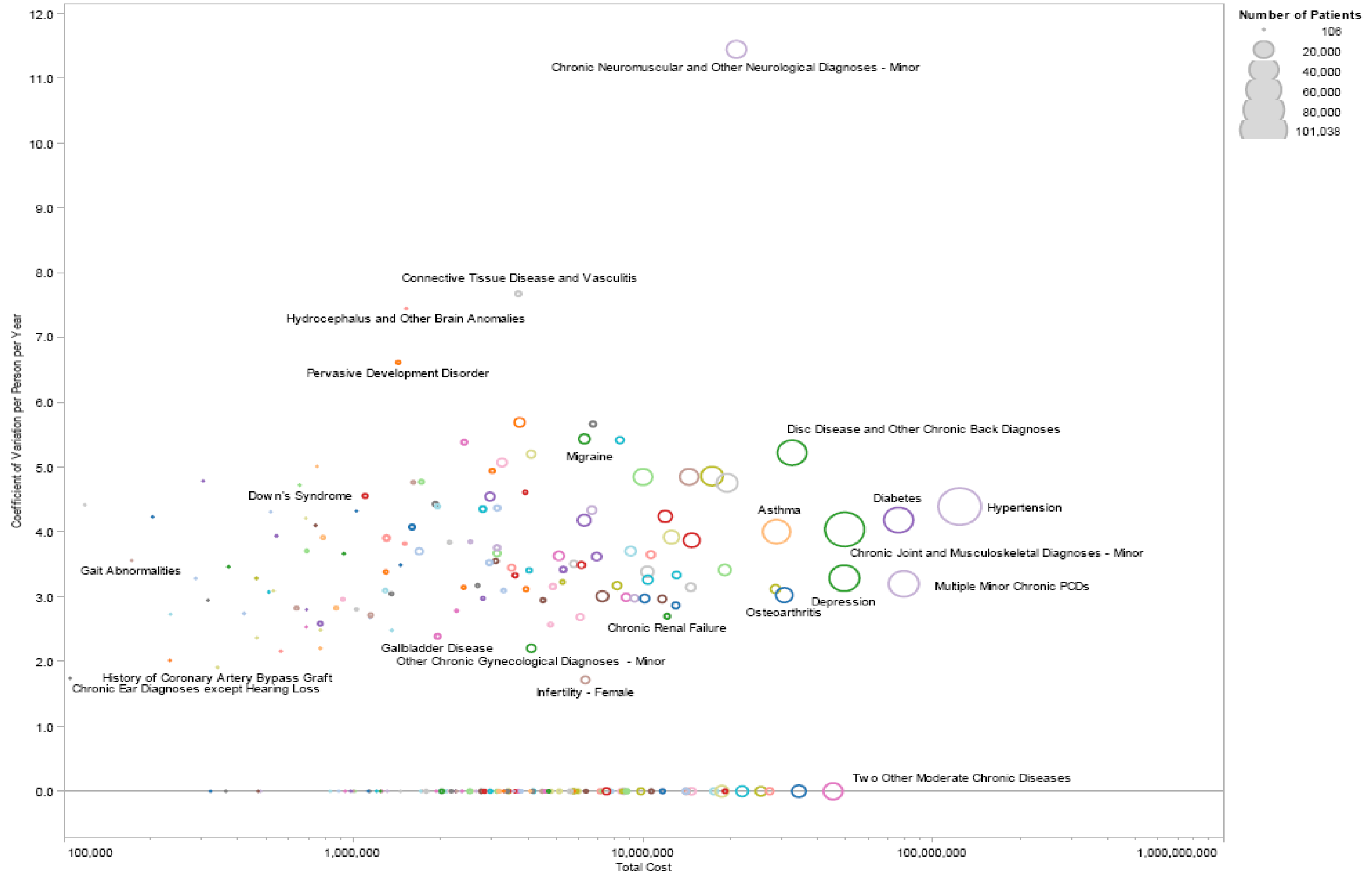
DIMR - (HSA_CALEDM_ZONES) / CPB - OCT 2011

Date: 2011-12-01

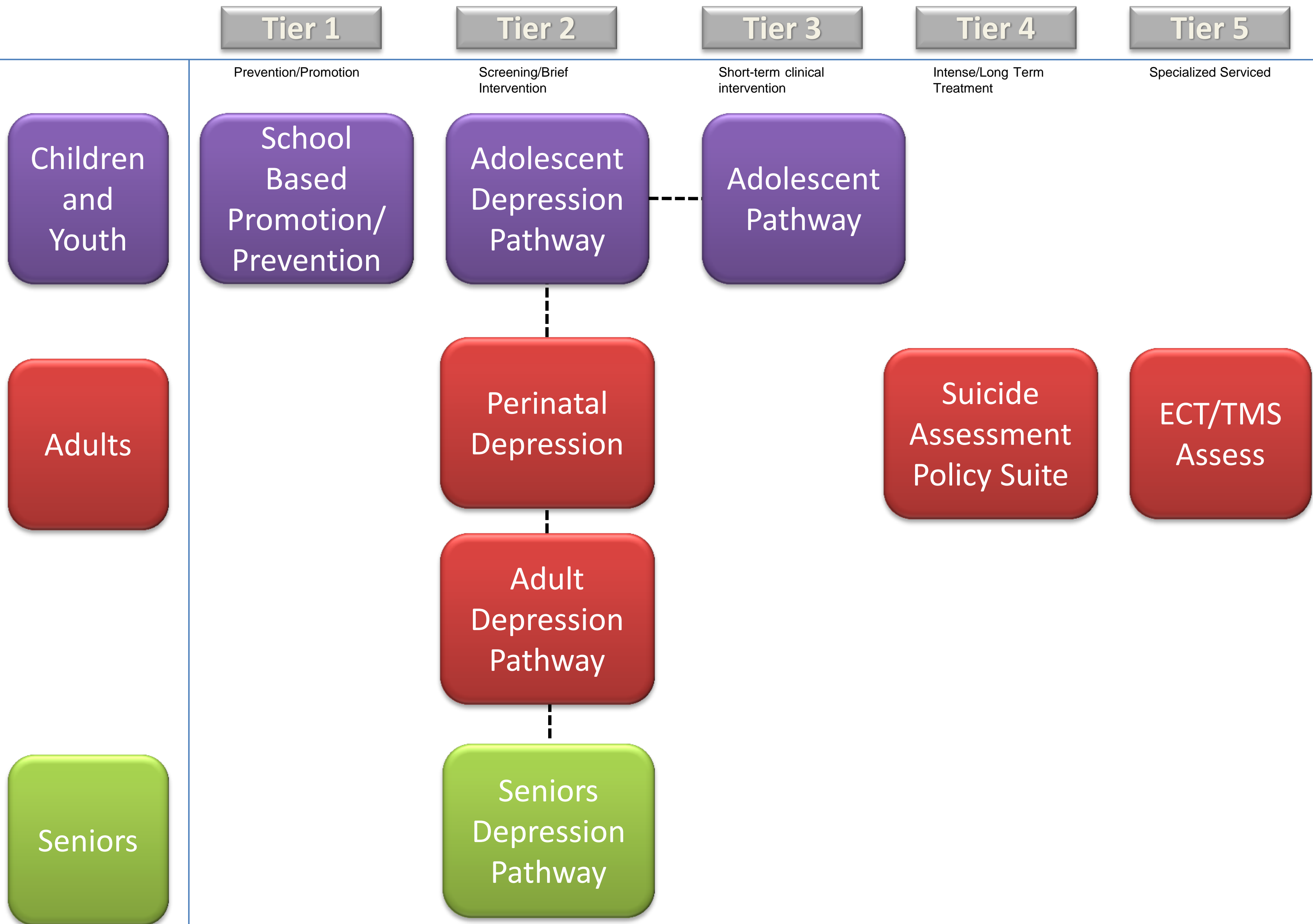
Treatment Cost for Depression



Treatment needs for depression are not equal



Sum of TotalCost vs. sum of CV. Color shows details about Health State. Size shows sum of Number of Patients. The data is filtered on CRG and minimum of Number of Patients. The CRG filter excludes 1000. The minimum of Number of Patients filter ranges from 100 to 106,648. The view is filtered on Health State, which excludes 1 Significant Acute Illness - Span 90 Excluding ENT and 1 Significant Acute Illness Excluding ENT. The marks are labeled by Health State.



Depression Program
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
Prevention/Promotion
Screening/Brief Intervention
Short-term clinical intervention
Intense/Long Term Treatment
Specialized Serviced
Children and Youth
School Based Promotion/ Prevention
Adolescent Depression Pathway
Adolescent Pathway
Adults
Perinatal Depression
Suicide Assessment Policy Suite
ECT/TMS Assess
Adult Depression Pathway
Seniors
Seniors Depression Pathway

Project Description

Continue work on developing, implementing and evaluating clinical pathways for depression in:

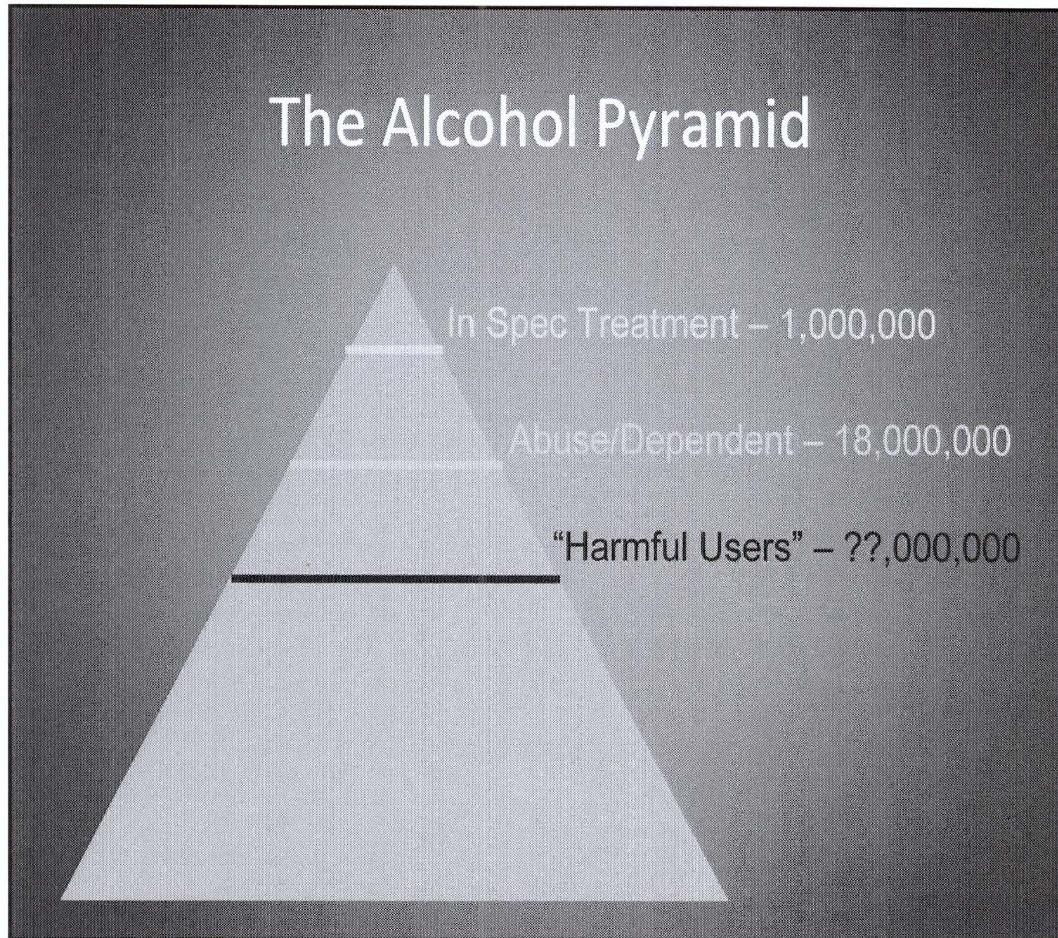
- **Adolescents**
- **Adults**
- **Seniors**

Focus on the primary care and community care areas of the continuum

Signature and Tier 1 Measure Project

AHS will be the best at treating depression in Canada within the next 5 years

Alberta alcohol costs:



Mark Gold

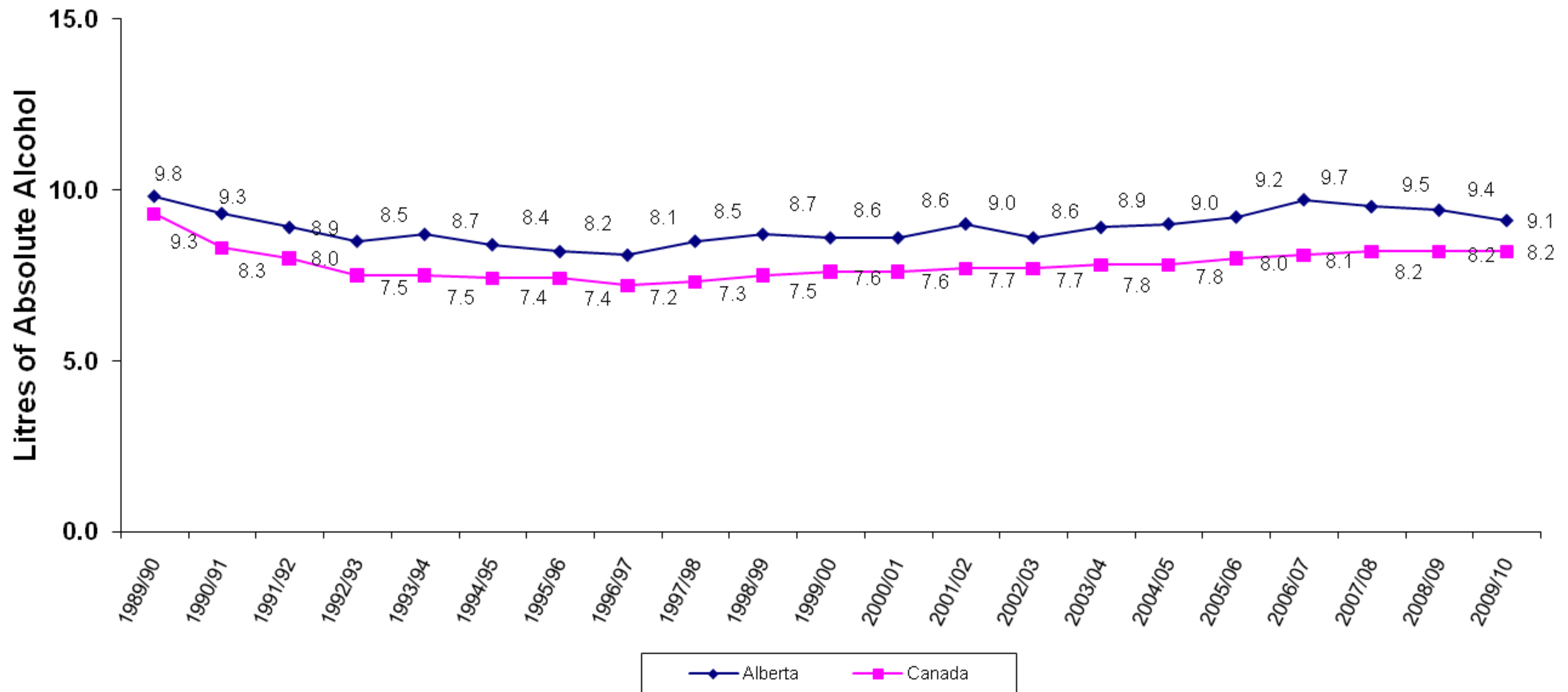
Project Description

- Develop, implement and evaluate a clinical pathway for alcohol use disorders in adults

- Initial focus on AHS Community Clinics

Non-medical Determinants of Health

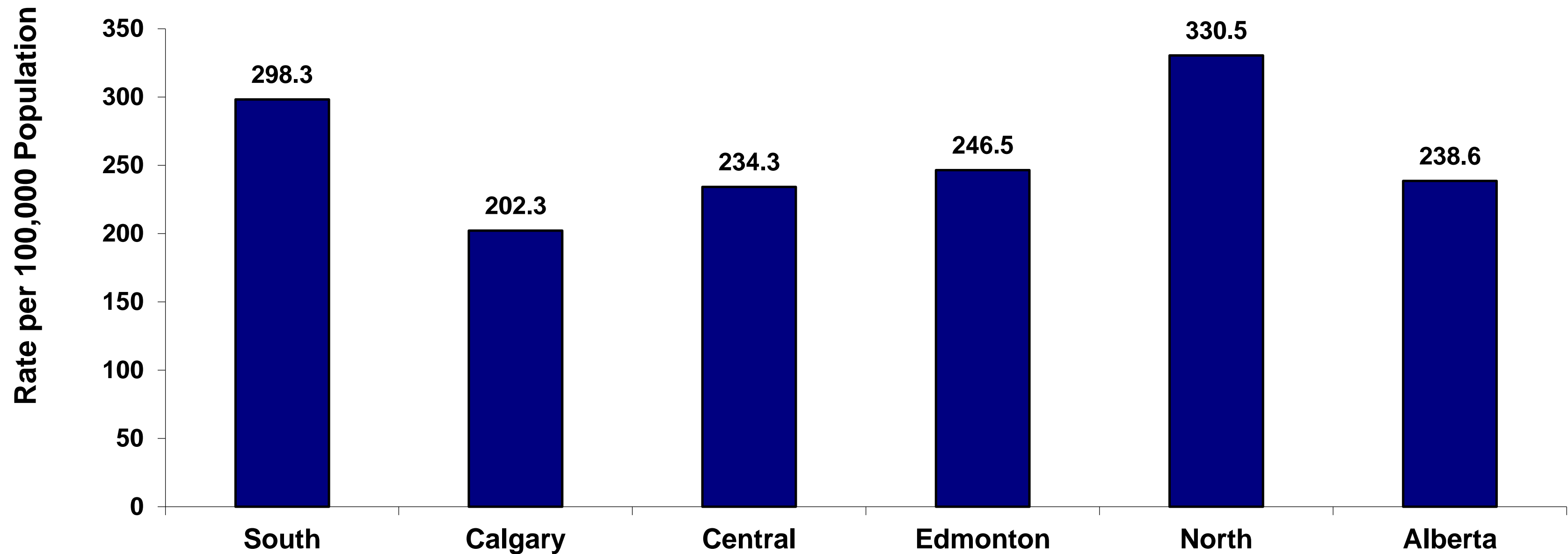
Per capita alcohol consumption (age15+), Alberta and Canada, 1989/90 – 2009/10



Note: Statistics Canada (2011). Per capita consumption is derived from population and sales statistics for the population aged 15 and older. Statistics on sales of alcoholic beverages by volume should not be

Health Status

Rates of suicidal behaviours per 100,000, Alberta Health Services Zones, 2008/09



Note: AHS Inpatient and Ambulatory Care data (2008–2009). Individuals who visited emergency rooms or were hospitalized for intentional self-harm

Benefits of AIM

- ✓ Reduce wait times for clients
- ✓ Increase system capacity
- ✓ Improve clinical care
- ✓ High feasibility
- ✓ Will have direct benefit to patients within 6 months of implementation
- ✓ Will support further SCN work – Depression Clinical Pathways

How do they do it?

AIM Impact on Quality

- Increase in % of patients with improved clinical outcomes and reduced symptoms
- Increase in patient access to appropriate level of primary and specialty care

- 90% of child and adolescent patients seen within 4 weeks for specialty AMH care

Reduction in % of unnecessary AMH ED visits

- 90% patient satisfaction

- Improved clinic efficiency
- Improved clinical care practices
- Improved teamwork and coordination
- Improved physician engagement

- Improved patient clinical outcomes
- Improved quality of care

Recovery From Addiction

Thank You!

Cathy Pryce

Norlien Foundation

Alberta family wellness initiative