Healthy Albertans and healthy communities in 15 years require collaborative planning today if we are to build the right community partnerships, strategies and approaches. This document provides an overview of the zone’s current demographics and system use, future projections, as well as innovative practices around the world.
How do we co-design and co-deliver a sustainable, quality health system that promotes healthy communities and provides appropriate access to services, programs and facilities across Alberta?

Demographics 2015

Population

2015: 475,233

Aging Population

66,817 people were age 65 and older. That’s 1 in 10 people.

Primary care 2014/15

78% reported having a Regular Family Doctor
Rates of diabetes are on the rise, as are chronic obstructive pulmonary disease (COPD) and hypertension. Diabetes is the fourth most common reason for hospital admissions in Central Zone. How can we improve this through prevention? Are there more effective ways of managing patients with diabetes?

Mental health and behavioral disorders are among the top 5 reasons for Emergency Department visits, and the second most common reason for Hospital Discharges in Central Zone. Should addiction and mental health be an area of focus in the zone? How can we better manage people before they have to go to the emergency department?
What Are We Planning For?

Demographics 2015

Population

- 2015: 475,233
- 2025: 587,657

24% growth over the next 10 years.

By 2025, 17% of people will be over 65 years of age.

Rates of chronic disease in Canada are increasing by 14% a year. How do we prepare for this?

We have an opportunity to prepare and plan for our future. If we improve population health (green line), we can make a slight difference. If we improve how we deliver care (grey line), we can have a significant impact on our financial health. If we are able to do both, we can significantly bend the cost curve over time (light blue). What’s possible?
Determinants of Health

What makes Canadians sick?

Your life
- Income
- Early childhood development
- Disability
- Education
- Gender
- Social exclusion
- Social safety net
- Race
- Employment / working conditions
- Safe and nutritious food
- Aboriginal status
- Community belonging
- Housing / homelessness

Your environment
- Air quality
- Civic infrastructure

Your biology
- Biology
- Genetics

Your healthcare
- Access to healthcare
- Wait times
- Healthcare system
Innovative Practices in Other Jurisdictions

**1. Alaska, United States**
Primary care, mental health and community services are integrated into one service model and specialists are embedded within primary care teams.

**2. Pennsylvania, United States**
The health system utilizes a hub and spoke model to integrate care between major hospitals, treatment centers and the community. Communication is streamlined between acute care and primary care. Patients have access to web portals where they can view personal health information, schedule appointments, order prescriptions, and contact physicians via e-mail.

**3. Germany**
Patients carry “Smart Cards” (electronic health cards) with their health information; providers can access patient information with the swipe of a card.

**4. South Devon & Torbay, United Kingdom**
Virtual Wards deliver multidisciplinary case management to complex high needs patients in the community, in order to reduce admissions to an acute care facility. This model utilizes a predictive risk assessment tool to identify patients at risk of unnecessary hospital admissions.

**5. Denmark**
Patients have 24-hour access to their general practitioner (GP) and are encouraged to seek after-hours care for minor emergencies. The GP is the “gatekeeper” and is responsible for referring patients to hospitals and specialty care.

**6. Canterbury, New Zealand**
Certain procedures formally conducted in hospital are now offered in the community, such as removal of skin lesions and treatment for heavy menstrual bleeding. HealthPathways have been developed to provide locally agreed-upon pathways for specific disease conditions, based on best practice evidence.
Quadruple Aim

Patient experience

Patient First Strategy

Our people

Health Plan & Business Plan

Our People Strategy

Patients & Families

AHS Vision, Mission & Values

Information Management / Information Technology Strategy

Financial Health & Value for Money

Patient and population outcomes

Financial health and value for money
Healthy Albertans.
Healthy Communities.
Together.
How to Stay Involved

Long range planning involves envisioning what will be needed in the future, and beginning to develop it today. Input gained from those who participate in engagement activities will be used to inform the future of health care in the zone and the province. A report on how the input was used will be provided to those who participated.

This is just the beginning. There will be further opportunities for participation as this work continues. One way to keep the conversation going is to contribute online. Visit www.ahs.ca/blog/longrangeplanning for information on how to stay involved, updates in the long range planning process, and a forum to share your thoughts on a number of topics.

This web page will be available to all Albertans, we encourage you to share it with your network and grow the conversation.

For additional information, please email community.engagement@ahs.ca.
Information Sources

- 2015 Alberta Provincial Registry data (POP_HLTH @AHSDRRX)
- Alberta Health PHC Community Profiles, March 2015
- Alberta Physician Claims, 2013-14
- https://tableau.albertahealthservices.ca/#/views/CommunityProfile/UtilizationRates?:iid
- Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada, using POHEM Model, Statistics Canada.
- Alberta Health and Wellness, Chronic Disease Projections 2006 to2035: Ischemic Heart Disease
- AHS Analytics (DIMR), Modeling the Future - Quantitative Scenarios
- Canadian Medical Association: https://www.cma.ca/En/Pages/health-equity.aspx