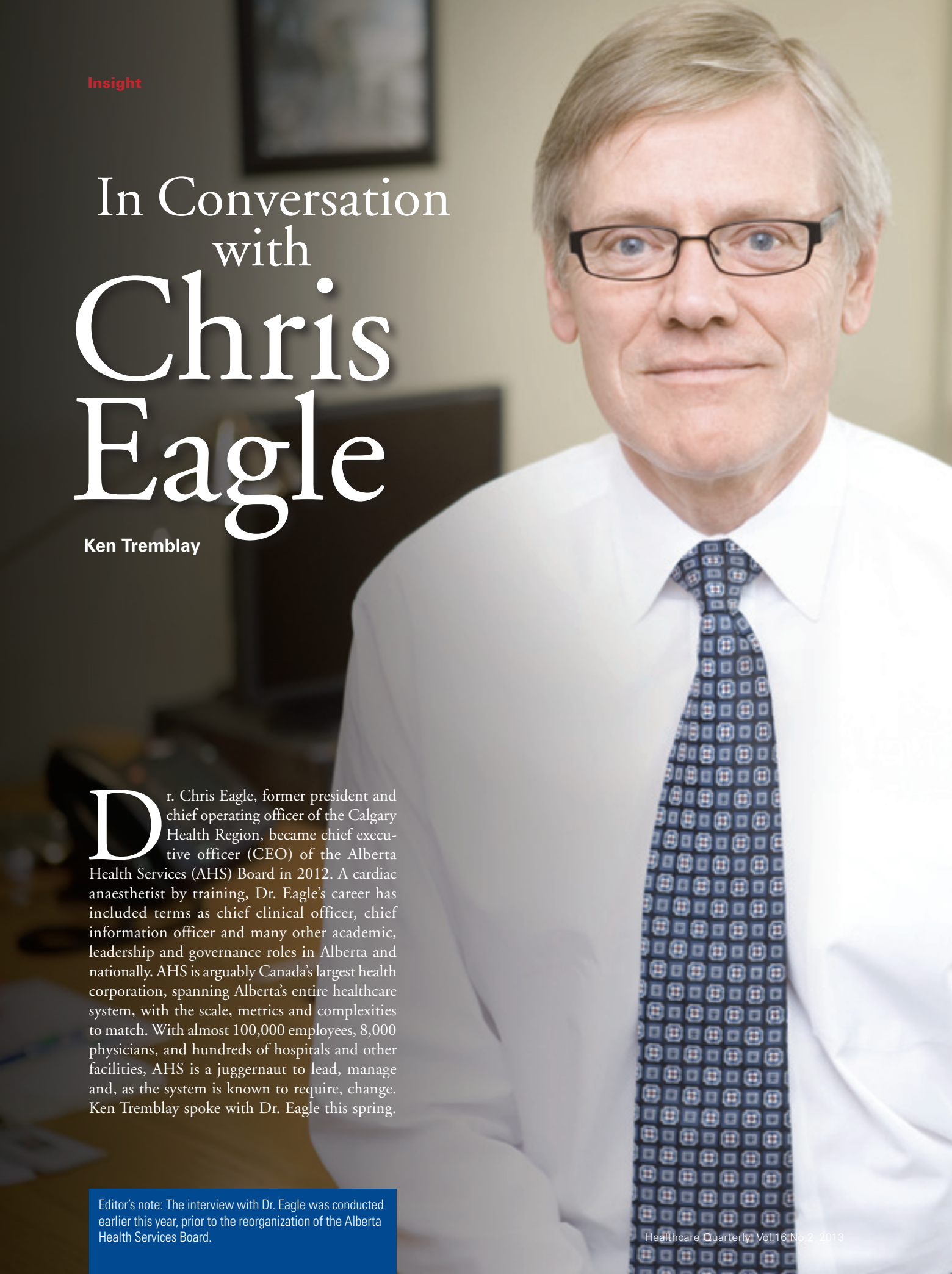
In Conversation with Chris Eagle

Ken Tremblay



Dr. Chris Eagle, former president and chief operating officer of the Calgary Health Region, became chief executive officer (CEO) of the Alberta Health Services (AHS) Board in 2012. A cardiac anaesthetist by training, Dr. Eagle's career has included terms as chief clinical officer, chief information officer and many other academic, leadership and governance roles in Alberta and nationally. AHS is arguably Canada's largest health corporation, spanning Alberta's entire healthcare system, with the scale, metrics and complexities to match. With almost 100,000 employees, 8,000 physicians, and hundreds of hospitals and other facilities, AHS is a juggernaut to lead, manage and, as the system is known to require, change. Ken Tremblay spoke with Dr. Eagle this spring.

Editor's note: The interview with Dr. Eagle was conducted earlier this year, prior to the reorganization of the Alberta Health Services Board.

HQ: One cannot help but notice the sheer scale of AHS – its clinical volumes and geography – and the mandate for and commitment to high-quality, accessible and sustainable services. As CEO, how do you get your head around the challenges that accompany that span of control?

CE: We serve a province about the size of France, with an annual budget of over $13 billion. As a single healthcare delivery system, there is nothing else quite like it, and the size is daunting.

When I became CEO in late 2010, our organization was highly centralized through a head office in Edmonton. Since that time we've tried to devolve that structure by creating five zones and a structure for cancer services. More recently, we have been working on a concept we call "self-managed operating units." A local hospital is expected to look after the population needs in the surrounding area along with a primary care network, seniors' centres, public health and so on. We're trying to break down a monolithic structure into one that is more locally responsive.

The dynamic to manage is what needs to be centralized and what needs to be done locally. For me, healthcare has always been a local issue. We maintain central functions like IT, finance and HR, while devolving clinical decision-making to the front line. It's been a bit of a journey, but we are making progress.

The other piece is what we call "strategic clinical networks" as we develop clinical pathways and best practices for the province. Strategic clinical networks are a means to take advantage of our clinical scale while keeping local delivery in place.

HQ: One of the consequences of morphing from distinct health authorities to AHS was the creation of a single employer for healthcare workers. What have been the advantages and challenges of that model given the direction for greater system integration?

CE: Regional health authorities worked closely together on labour issues through the provincial health boards of Alberta, which helped them coordinate labour strategies; it's not a new concept to have a provincial approach to this. By bringing everything together, we have single payroll, finance and HR systems – we have built really good system-wide infrastructure. Our payroll system serves 80,000 people: it's very large and one of the largest e-People implementations in North America. There is an economy of scale that comes out of that.

By being a single employer, we have been able to work systematically on topics like staff scheduling, rotations and workforce mix (i.e., the right mix of nurse practitioners, nurses, LPNs, etc.).

One of our major challenges, as with every healthcare organization in the country, is the boom, bust and echo demographic. We have an aging workforce, and trying to make the workplace attractive for Millennials, Gen-Xers and Gen-Yers is an ongoing challenge.

HQ: Shifting system capacity and care to community-based models factors into several of your strategic directions. What have been the highlights of that direction, and what lies ahead for AHS?

CE: We look much more at what [capacity] we can build in the community versus urban hospitals. We are becoming more community focused, and there are a few tools available to us. In 2003, Alberta started building primary care networks as partnerships between groups of family physicians and the health system. They offered family physicians extra funding to employ different healthcare workers and to deliver care in ways [that were] different from the fee-for-service model in Alberta at the time.

The primary care networks give us a really good platform. We are now developing family care centres (FCCs) as the next generation of these networks. Currently, we have three of them up and running. The family care centres have been effective in dealing with populations not well covered by physicians, for a variety of reasons.

A family care centre was put in place after the Slave Lake fire, in which a lot of the town burned down. Five of 13 physicians, who lost their homes, left the community. We needed something that would support other health workers in a clinic environment to allow same-day access to healthcare. We've got a pretty good model now.

In east Calgary and east Edmonton, we have two FCCs serving communities with low socioeconomic status, a high percentage of immigrants, a high percentage of people whose original language is not English, significant numbers of unmarried mothers and the like. Family care centres have allowed us to enrol people into a primary care model where access was a challenge.

More recently, and like most large integrated systems, we have studied the people using our healthcare system. We have identified that 5% of the population use about 60% of healthcare's resources, not because of any failing of the patients. Rather, they just can't get access to the right services. We're looking at what it would take to produce higher-quality and lower-cost care for that group. How do you deliver the right services for the people who use the services the most? How do we get the acute care system and the community really working effectively together?

HQ: How have investments in information technology (IT) assisted AHS in its mandate to improve access and drive system performance? What are the lessons learned for other jurisdictions?

CE: There are two different types of systems – the clinical systems and the non-clinical systems. With non-clinical systems,

I noted the benefits of single finance and HR systems for a large integrated system like ours; for example, costs. However, I'm most interested in IT in the clinical areas. Large integrated healthcare systems are successful because of their clinical IT platforms, platforms that are useful for clinicians wherever they practise in the province.

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Netcare, a great tool that started in the former Capital Health region, has been rolled out across the province. It allows physicians to look at a variety of laboratory and x-ray information; it gives physicians at the bedside look-up functions. They can access a lot of information about patients right away – no matter where the patient came from or the provider.

It's not particularly interactive [yet], where you can enter physician orders and update records. We're looking at what the next generation of a clinical information system would be for the province. We have looked to places like Intermountain Health, Geisinger and Kaiser Permanente to learn about large integrated clinical information systems. Right now, we are trying to decide what that platform would be, then how it might roll out across the province.

The other important piece is that patients have access to their information too. Alberta has developed a patient portal with the Department of Health. Still in the early days, the ability of patients to look up their own information is really important.

The biggest issue for clinical information systems is making the system serve the needs of the clinicians. In order to work, it has to have a good value proposition for clinicians, in terms of results, decision support and accelerated order entry. If [a system] cannot do that, then you're not going to have physicians buying into it. We have been very attentive to the needs of the clinicians and found early champions.

HQ: Chronic disease and primary care – what's Alberta doing right, and how do you know? Are you reducing the frequency, severity and duration of hospital stays?

CE: While we're optimistic, I cannot say that we've got the evidence that we are doing a better job than anywhere else. We certainly have the ability – good information about patient populations and the ability to track how patients flow through the system, especially through our clinical networks, which do a good job with chronic diseases. One of the mandates of strategic clinical networks is to ascertain if they are making a difference in any of the chronic disease areas – myocardial infarction, stroke, depression etc.

For example, the primary care network of southeast Edmonton took a particular interest in its diabetic population – working with Alberta Health Services. It had significant success in driving biochemical markers, like hemoglobin A1C, across its entire service population by using the electronic health records to track better diabetic control across the system. [This network] is a benchmark for us in terms of how we can work through primary care networks on specific chronic diseases to improve outcomes.

HQ: As arguably the province's only [public] provider, you own healthcare's advocacy agenda too. How do your relate to the minister of health and the deputy minister?

CE: I cannot say we own the healthcare advocacy agenda; there are so many advocates for patient care or disease groups. Although we are very important and we do advocate strongly for different types of healthcare delivery, we have very active professional associations and groups such as the Alberta Medical Association, the colleges, the Alberta Association of Registered Nurses, Friends of Medicare etc. There are many advocates for healthcare; we're one, but certainly not the only and perhaps not even the dominant one.

Being the only provider organization, we do have a very close relationship with government. It's quite different from when there were nine regional health authorities. Our physicians and the public are sometimes confused about what is a government issue and what is an Alberta Health Services issue. We have a mandate and roles document that assigns who is responsible for what and delineates responsibilities for the Department of Health and Alberta Health Services. It's not perfect yet. We're still working on fine-tuning the relationship.

HQ: Given the scale of AHS, how does the AHS Board of Directors add value to the discussion around the patient experience?

CE: I've been through several generations of healthcare structures in Alberta. When we had independent hospitals, the board brought business expertise and a lot of community knowledge to hospital governance. When the regions were formed, we had board members who had significant business experience and a good feel for what was happening in their local region – whether it was Calgary, Edmonton or one of the rural regions.

With Alberta Health Services, the transition has been to board members who are less attentive to community issues and much more attentive to running a business with $13 billion in expenditures. That's a very large business, needing signifi-

cant business oversight skills on the board. That's changed the nature of the boards and also their function: collapsing boards has really focused the need for good business management.

To get public and community input [back] into things, we started a number of health advisory councils around the province. There are 13 geographical regions within the province, [each with] a health advisory council whose job is to help us get feedback from the public. Health advisory councils are appointed by the board and report to the board as outreach platforms for AHS. Some are geographically based and some are health population based, such as the Mental Health Council, the Cancer Council, a Patient and Family Council that looks at the issues particularly around the patient experience and a Wisdom Council that looks at the issues of First Nations, Inuit and Metis.

We've changed the way we balance community input and business expertise on the board. It's one of the consequences of size.

HQ: As CEO, how do you get to know and relate to your own organization? Will we see you on an upcoming episode of *Undercover Boss Canada*?

CE: I don't think *Undercover Boss Canada* would be quite my style! Staff would be a little perplexed as to what an out-of-date anaesthetist was doing wandering around! It's a very large organization, and I spend a fair bit of time being out and about – from the north to the south of the province. You can never spend enough time walking around. In the old days, a hospital CEO could know the facility really well: staff by name, career histories. It's much harder to do that in an organization of this size.

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We make significant attempts to offset the size issue, such as use the province's telehealth network for town halls or use online chat rooms. I bring in selected people from different constituencies, have meetings with front-line managers on a rotational basis and meet with groups of physicians on a rotational basis. So you can get a cross-sectional look [at the organization]. You could say these are not as good as management by walking around – perhaps they aren't. But you have to live in the environment you have, so we try and make that work.

HQ: How do you partner with physicians in a model like AHS?

CE: I come at this as a physician. I believe that physicians and administrative leaders can make very good operational decisions together. Throughout our organization – from the program level, department level, right up to chief operating officer – we have administrators teamed up with physician co-leads. There are many physicians involved in the administration of Alberta Health Services, each bringing that clinical perspective to bear. That's one way.

Another way is the partnerships we have with the primary care networks. They give us a working business relationship with groups of physicians who are really not working in the Alberta Health Services domain; they work in their own practices.

Medical staff bylaws set up a number of mechanisms to work with physicians. We have zone medical staff associations and strong linkages between the zone medical leaders and leaders of the medical staff associations. We have a good working relationship with the Alberta Medical Association that is formalized in a number of different ways. We've tried to look for more than one way to partner with physicians. For example, we are opportunistic with our clinical networks; clinicians working with us from across the province have been accepted by many groups. We've looked upon opportunities like that as a means to develop new models of care collaboratively with physicians. I think that's caught their excitement.

We have a lot of tension right now in Alberta with negotiations between the government and the Alberta Medical Association. The relationship between Alberta Health Services and physicians is improving, perhaps with more trust now than there was when I took on this role.

HQ: Healthcare's critics often cite its fixation on diseases rather than upstream investments in wellness and prevention. How does AHS invest in disease prevention and wellness and, perhaps using the example of diabetes, how have these efforts affected population health and the costs and outcomes for your organization?

CE: It's difficult to change things quickly in healthcare for a variety of reasons. Healthcare, particularly in Alberta, is acute care based. We have a lot of infrastructure, and that limits our flexibility. There are many jobs at stake; most of the employees in the healthcare system remain in the acute care sector. Trying to reshape the healthcare system to reflect the today's demands – in terms of creating more community services and investments in wellness and prevention – is difficult.

AHS flattened its increases for acute care over the past couple of years: the percentage of acute care expenditures is becoming less, and the percentage spent in the community is more. We hope [this approach] will see fewer visits to emergency departments. We believe that a strong investment in community [capacity] will be good.

When you consider services for wellness and prevention, you rapidly run into the social determinants of health. The healthcare

system is only one factor; social determinants force people working on wellness to be much more collaborative than the typical acute care–focused physician or nurse. We're working with government departments, from education to social services to environment, to drive wellness in the community. We can't own the entire wellness initiative – that would be the wrong thing to do – but can be at the table working collaboratively with other sectors that impact health.

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However, our clinicians and leaders are trained in a very different environment. Working effectively in a multi-stakeholder social environment is not what most have been trained to do. There is a learning curve and significant change for organizations and people in them: how we develop a more open space for disease prevention and wellness. It's easy to say we should be focusing on wellness, but starting that work with the many government, for-profit, not-for-profit, volunteer and philanthropic organizations in the community is a daunting task.

HQ: As a physician leader, what observations or feedback would you want to share with clinical colleagues reading this interview?

CE: The health system has become very complex over the 30 years that I've been working in it. The education physicians receive about how to work in complex systems – recalling my medical school and residency experience – was and is very little: How do you engage the system? What is the system there for? And how do you solve problems in a system?

We're trying to break down a monolithic structure into one that is more locally responsive.

There are many learning opportunities for physicians if they don't approach it with the idea that someone is doing something wrong or is malevolent toward them, and I certainly encourage more leadership or management education for physicians, such as the PMI [Physician Management Institute] or executive education courses we sponsor with the University of Alberta and the University of Calgary. You have to be able to have a dialogue about how to move the system from point A to point B. It's more complicated than a front-line physician or nurse might think. Often, people think there's a silver bullet – I wish I had more silver bullets, but I don't.

HQ: What do you hope will be your leadership legacy at AHS?

CE: There are three domains: the people side of the business, local healthcare and then corporate. We have a very large workforce. I would like every member of that workforce to feel that what they do when they come to work actually makes a difference and they are a valued partner or employee. That is issue one.

Issue two is that we look more at local populations as we answer some of the questions you have been asking: can we improve the quality of health for Albertans across the board – from north to south, east to west? That should be our major goal and focus.

On the corporate side, I'd like an organization that showcases performance and contributes as a learning organization – that we have great systems in place and the structures to deliver the best healthcare we can.

HQ: Thank you.