



10 Years
eHEALTH INITIATIVE
Real Solutions. Better Health.

Disease Management – The Role of HIEs and Patient Portals

Dial-in information:
1.800.908.8370

November 22, 2011

About eHealth Initiative (eHI)

- Since 2001, only national, non-partisan group that represents all the stakeholders in health care.
- Mission to promote use of information and technology in healthcare to improve quality, safety and efficiency.
- Focused on education and advocacy.
- Coalition of over 200 organizations is one of most influential groups in data issues, HIT and HIE.
- eHI is the only group tracking the progress of over 260 regional, state and local initiatives working on health information exchange for 8 years.



What Does eHI Do?

- Work with our members to influence policy
- Convene multi-stakeholders to build consensus
- Members contribute through virtual forums:
 - Meaningful Use and Health Reform Policy
 - Connecting Communities through Health Information Exchange
 - HIT Infrastructure for Accountable Care
 - Using Health IT to Coordinate Care
 - Data Analytics and Research
- Inform and mobilize reports, weekly newsletters, educational events and policy alerts.



Housekeeping Issues

- All lines are muted
 - To ask a question or make a comment, please submit via the chat feature and we will address them in the order received at the appropriate time
- The webinar is being recorded.
 - Members can access slides and replays of any webinar for free from eHI's store
 - Non-members can purchase access to any webinar replay for \$25.00
 - eHI Store
 - <http://www.ehealthinitiative.org/store.html>



Thank You to Our Sponsor



Overview of Our Agenda

- **Introduction and Welcome (3:00 – 3:10 PM)**
 - Jennifer Covich Bordenick, Chief Executive Officer, eHealth Initiative
- **Self-management Education (3:10 – 3:25 PM)**
 - Dr. Kate Lorig, Director, Stanford Patient Education Research Center
- **Disease Management – The Role of HIEs and Patient Portals (3:25 – 3:55 PM)**
 - Peggy Denness, MSW, Client Manager, Orion Health
 - Dr. Chris Hobson, Chief Medical Officer, Orion Health
- **Questions and Final Thoughts (3:55 – 4:25 PM)**
- **Closing (4:25 – 4:30 PM)**
 - Jennifer Covich Bordenick, Chief Executive Officer, eHealth Initiative



Dr. Kate Lorig

Professor Emeriti, Stanford
University School of Medicine,

Director, Stanford Patient
Education Research Center



Self-Management Education: More than a nice extra

Kate Lorig, DrPH

Stanford Patient Education Center

1000 Welch Road, Suite 204

Palo Alto CA 94304

650-723-7935

self-management@stanford.edu

[http:// patienteducation.stanford.edu](http://patienteducation.stanford.edu)



**STANFORD
UNIVERSITY**

So Why Should We Care?

- **Self-management programs focus on preparing people with arthritis for the 99% of the time they live outside of the health care system.**
- **These programs give individuals the skill to improve physical and mental health, health behaviors and quality of life as well as the confidence to use these skills. Such improvements can lead to improved quality of life and reduced need for health care.**

Foundation of Better Choices, Better Health - Diabetes

As with all of Stanford's Programs:

- Built on structured patient and professional needs assessments
- Systematically use strategies to enhance self-efficacy:
 - ✓ *Goal Setting*
 - ✓ *Modeling*
 - ✓ *Reinterpretation of Symptoms*
 - ✓ *Peer support*
 - ✓ *Social Networking*



Characteristics of Better Choices, Better Health - Diabetes

- **Six-week workshop (entirely on-line anywhere there is Internet access – even dial up)**
- **Online curriculum same content as small group community workshops**
- **20-25 participants**
- **New workshop session starts each week**
- **No “real-time” commitment – any time/any day**
- **Peer-led by two trained facilitators– supervised by online CDE mentor/safety monitor (most of whom are CDEs)**
- **Highly interactive (discussion boards)**
- **Participants asked to log on 2-3 times a week for a total of 1-2 hours**

Diabetes Self-Management

What is Taught?

6 weeks **Sharing/Problem Solving**

6 weeks **Action Planning**

6 weeks **Healthy Eating**

3 weeks **Monitoring Glucose**

1 week **Weight Management**

2 weeks **Exercise**

1 week **Preventing Hypoglycemia**

3 weeks **Stress/Depression**

1 week **Medications**

1 week **Preventing Complications**

1 week **Foot care**

2 weeks **Communication Skills**

1 week **Sick Days**

1 week **Sleep**

1 week **Working with Providers**

2 weeks **Understanding Test Results**

1 week **Cholesterol**

1 week **High Blood Pressure**

What makes BCBH-Diabetes Safe

- **All Facilitators have six weeks of training and work from detailed manuals**
- **All Facilitators have rapid access to a mentor who is a CDE who has also been trained in the program**
- **Posts with erroneous information and disrespectful posts can be removed**
- **Participants are never given individual clinical advice**

The Evidence

Randomized six months N=395 (w/100 Native Americans)*

- ✓ **Reduced A1c - For those with a baseline of 7 or above there was a -.6 difference at six months between treatment and control groups**
- ✓ **Improved self-efficacy to manage conditions**
- ✓ **Improved patient activation**
- ✓ **Telephone reinforcement at 18 months did not improve outcomes**

***Lorig K, Ritter PL, Laurent DD, Plant K, Green M, Jernigan VBB, Case S. Online Diabetes Self-Management Program: A randomized study. *Diabetes Care*, 33(6):1275-1281, 2010.**

The Evidence

Albert Longitudinal study

277 people for all over Canada (mostly Alberta)

Took part in one of 12 on-line workshops

Male 24%

Mean Age 47.7 years

Significant 6 month improvements

- Depression
- Fatigue
- Role Function
- Medication Adherence
- Self-Efficacy

- MD visits in past six months -14% (.89 visits)

Conclusions

- **Self-Management Programs that include social networking can improve medical, role and emotional management**
- **May be cost effective and at best cost neutral**
- **Differs from case management in that it allows people to self-manage rather than being managed.**

Peggy Denness, MSW

Client Manager, Orion Health

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Dr. Chris Hobson

Chief Medical Officer, Orion Health

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Orion Health

Disease

Management –

The Role of HIEs and

Patient Portals

Agenda

- I. DM Overview
- II. DM Trends
- III. Transforming DM via HIE Integration

DM OVERVIEW

Why is DM Needed?

Cardiovascular (CVD) Disease Statistics

★49.7% of U.S. adults (an estimated 107.3 million persons) have at least one of the three risk factors, 21.3% had two of the three risk factors, and 2.4% had all three

★CVD is the leading cause of death in the United States and is responsible for 17% of national health expenditures

★Annual direct and overall costs resulting from CVD are estimated at \$273 billion and \$444 billion

★By 2030, 40.5% of the US population will have some form of CVD, costing the healthcare system an estimated \$1 trillion every year

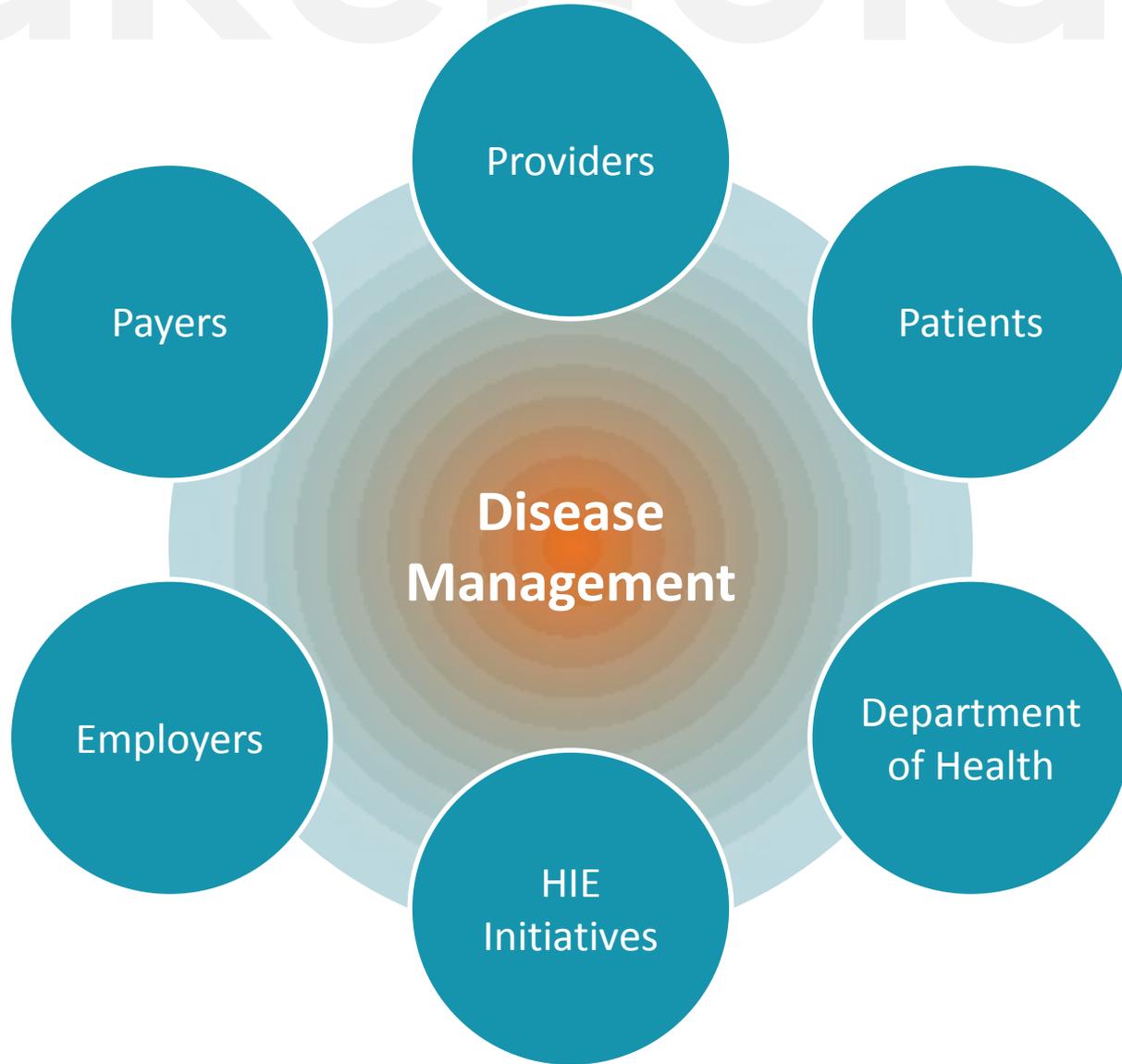
Disease Management Overview

★ DM evolved to:

- ★ Enhance quality of care for chronic disease
- ★ Improve outcomes for patients with chronic disease
- ★ Establish protocols and best practice guidelines to manage chronic disease
- ★ Manage costs associated with chronic disease, specifically:
 - ★ Inpatient admissions
 - ★ Re-admission
 - ★ Emergency Department utilization
 - ★ Specialty service utilization
- ★ Drive prevention programs to reduce chronic disease population

DM TRENDS

Current DM Stakeholder Models



Provider Models

★ Motivation

- ★ Improve quality of care
- ★ Comply with payer standards
- ★ Protect against liability

★ Implementation Methods

- ★ Implement professional organization standards for care
- ★ Implement payer care protocols and standards

★ Technical Approach

- ★ Practice-centric EMR with DM modules
- ★ Participate with HIE
- ★ Utilize EMR based patient portals

★ Limitations

- ★ Reliance on practice-centric EMR
- ★ Complying with multiple payer centered DM protocols

Patient Models

★ Motivation

- ★ Experience a better, healthier lifestyle
- ★ Maintain employment and productivity
- ★ Financial benefits via reduced medical costs

★ Implementation Methods

- ★ Participate in community-based programs
- ★ Engage with plan centered DM programs

★ Technical Approach

- ★ Use of patient portals – payer-based and provider-based
- ★ Use of tools like Health Vault and other consumer driven solutions
- ★ Medical device based solutions

★ Limitations

- ★ Connecting the patient-based solutions to providers and treatment teams
- ★ Access to technology to engage in programs
- ★ TIME – So many solutions, so little time

Department of Health (DOH) Models

★ Motivation

- ★ Improving health within the community
- ★ Prevent the spread of disease
- ★ Address the growth of non-communicable disease

★ Implementation Methods

- ★ Implement reporting programs with Providers
- ★ Via community-based programs (Immunizations, etc.)
- ★ Drive legislation for healthier citizens

★ Technical Approach

- ★ DOH portals
- ★ Reporting mechanisms
- ★ Use of social media and other forms of media

★ Limitations

- ★ Inability to connect with the systems providers use most often to document care
- ★ Unable to link directly to patients
- ★ Moving beyond communicable illness to chronic non-communicable disease

HIE Models

★ Motivation

- ★ Improve community health via centralized method to track and manage care
- ★ Engage with government support of HIEs and technology to improve health and outcomes
- ★ Create value via an HIE to ensure sustainability

★ Implementation Methods

- ★ Connect providers regionally
- ★ Ensure access to patient information across providers

★ Technical Approach

- ★ Through web-based HIE capabilities
- ★ Integrate additional services such as DM protocols and patient portals

★ Limitations

- ★ Achieving acceptance of HIE by providers and patients
- ★ Liability and privacy concerns regarding data sourced from the exchange
- ★ Redundancy with other tools – payer portals, member portals, EMR capabilities, etc.

Employer Models

★ Motivation

- ★ Engage employees in healthier choices
- ★ Control escalating benefit costs
- ★ Increase productivity among employees

★ Implementation Methods

- ★ Work with Payers to create DM focused programs
- ★ Offer employee-focused programs (EAP, industrial medicine, health club membership incentive)

★ Technical Approach

- ★ Use of employer tools to track employee utilization tools
- ★ Use of other patient focused solutions and tools

★ Limitations

- ★ Cost of running employer-centered programs
- ★ Employee engagement and privacy concerns
- ★ Demonstrating results to organization and employees

Payer Models

★ Motivation

- ★ Improve health of members
- ★ Offer programs that differentiate via engagement and outcomes
- ★ Manage cost containment

★ Implementation Methods

- ★ Create and implement care protocols and standards
- ★ Target specific chronic conditions
- ★ Monitor adherence to protocols
- ★ Offer member focused case management services and member based incentives
- ★ Develop programs targeted to employers, members and providers

★ Technical Approach

- ★ Utilize plan-sponsored portals targeted to members, providers and employers
- ★ Introduce data analytic tools to assess outcomes and manage reporting

★ Limitations

- ★ Payer marketshare
- ★ Timeframes and relevance of information delivered
- ★ Time!

CURRENT DM TRENDS

New Models for Care Delivery

- ★ New Trends in DM
 - ★ Patient Centered Medical Home (PCMH)
 - ★ Accountable Care Organizations (ACO)
 - ★ Bundled Payments
- ★ Each of these models drive to:
 - ★ Improve management of chronic disease
 - ★ Increase compliance with best-practices
 - ★ Enhance methods of engaging patients in their care
 - ★ Improve outcomes
 - ★ Cost management associated with treating patients with chronic disease
- ★ Data management – capture, share, analyze and report is key
- ★ Technology is essential to the success of the new DM Models

How Will These Models Work Together?

PCMH

- Care coordination focused on outpatient population-PCP mode

ACOs

- Care coordination focused on care continuum model
- Shared risk taken by extended care organization

Common Characteristics

- Driven by payers and providers
- Emphasis on DM via case management and prevention
- Communication among care team essential
- Reporting is essential to track utilization, adherence to protocols, outcomes, and financial data

Bundled Payments

- Care coordination similar to ACO
- Episode of care reimbursement model
- Incentive-based **provider and patient**

Guideline Measures Are Only Partially Followed

Evidence-based guideline adherence, by chronic conditions

Quality Indicators	# of eligible patients	% of patients receiving recommended care		
		All	Commercially Insured	Medicare
Coronary artery disease (CAD) patients with ACE inhibitor	26,220	35%	36%	29%
Hyperlipidemia patients with statin or acceptable alternative	622,110	36%	38%	27%
Congestive heart failure (CHF) patients with beta blocker	5,883	50%	53%	39%
Congestive heart failure (CHF) patients with ACE inhibitor	5,883	55%	58%	44%
Depression patients with SSRIs or SNRIs	26,068	56%	56%	45%
Depression patients with any antidepressants	26,068	85%	85%	72%
Migraine patients with narcotics	33,984	57%	57%	66%
Adult persistent asthma patients with ICS	53,470	78%	79%	58%
Diabetes patients with oral diabetes therapy	162,394	80%	81%	74%
Pediatric persistent asthma patients with ICS	8,378	97%	97%	96%*

* Medicaid Pediatric Population Data

The Next Generation of DM - A Unified Platform

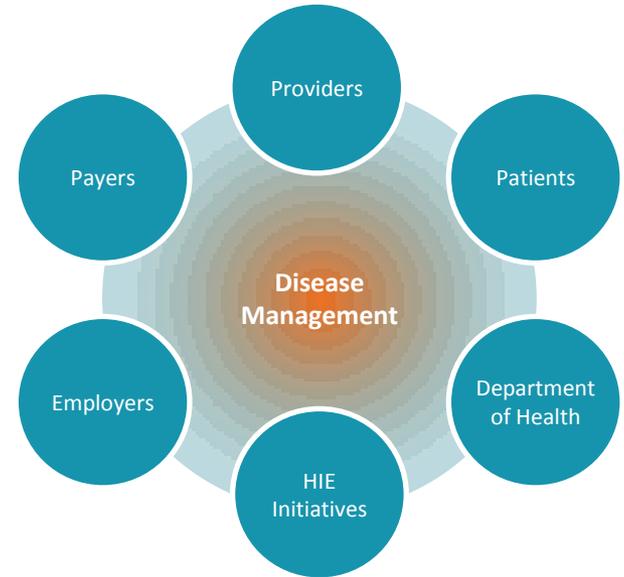
Focus on the Integration of Care

As healthcare systems face **rising costs** from the **aging population** and **burden of chronic illnesses**, all stakeholders will be called upon to:

- ★ Engage and empower patients
- ★ Streamline care and eliminate duplication of healthcare services
- ★ Control costs
- ★ Collaborate together and focus on a shared care plan
- ★ Maximize the use of technology for information sharing, especially HIEs

How Can this be Done?

- ★ Technical mechanisms to support comprehensive DM:
 - ★ Provision of single best patient record
 - ★ Technology is vendor agnostic
 - ★ Every member of the care team including patients has appropriate access to patient record
 - ★ Shared care plan
 - ★ Reporting based on comprehensive data



Building Blocks for Integrated DM



Patients

Active Patient Involvement

Coordinated Cost-effective Quality Care

Improved Quality of Care

Shared Information

Quality Data

Technology

Patient & Caregiver Integration

Patient Portal Integrated with Disease Mgt
Workflow Integration
Disease & Case Management

Process Integration

Administrative/Billing/OE / Med. Rec. / Prescribing

Information Integration

Clinical and Patient Portal – EPR / EHR / HIE

Application Integration
Integration Engine & Standards



Professionals

Shared Responsibility for Healthcare

MDT Workflow & Decision Support

Process Automation and Standardization

Shared Single View of Best Patient Record

Resource Optimization

Integration Level

Patient-centric BI

Cross Boundary Integration

Building Blocks for Integrated DM



Payers

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Integration Level

Patient-centric BI

Cross Boundary Integration

Single Best Patient Record

ORION HEALTH 84568-4564 CARDINAL John (M/61 years) [] 9:57 14-9

rded

Document View Showing All Mark All As Read Group By Category Sort By Date

Logout

Common

My Details

Worklists

My

Patient Portal

Providers

Preferences

Collections

Patients

Worklists

Links

webPAS

Messaging

Sharepoint

Demographics from PAS

84568-4564 CARDINAL, John Q

Other Identifiers		Emergency Contact	
NHR	104532R	Name	JARGON, Carol
		Relationship	Sister
		Phone	(408) 455-2112

Demographics		Primary Care Provider	
Sex	Male	Name	WOOD, Brandon R
Date of Birth	12 Nov 1949 (61 years)	Clinic	Bough Family Clinic
Address	840 Chester Ave Pasadena	Address	315 Maple Ave Pasadena
Phone	(463) 321-4568	Phone	(468) 456-2421

Problem List

Problem	Diagnosed	Diagnosed Date	Status
Hypertension	1997	Dr Alan Peterson	ACTIVE
NIDDM	2005	Dr Joe Martin	ACTIVE
Ischaemic Heart Disease	2006	Dr Joe Martin	ACTIVE
Congestive Heart Failure	2006	Dr Sam French	ACTIVE
Melanoma	2002	Dr Alan Davies	INACTIVE

Medications

Medication	SIG	Effective Dates	Status
Potassium Cyanide 1000MG TAB	Take 3 times a day	17-Dec-2010 - 20-Dec-2010	No Longer Active
ASPRIN 100MG TAB	Take after meal	21-Apr-2006	Active
FRUSEMIDE 40MG TAB	Take after breakfast	21-Apr-2006	Active
CILAZAPRIL 2.5MG TAB	As directed by physician	21-Apr-2006	Active

Allergies & Alerts from ED System

Details	Reaction	Severity	Date Entered
Penicillin	Hives	Moderate	03-Jun-1995

Document View

Showing All Mark All As Read

Group By Category Sort By Date

Patient Summary

CDM Diabetes Summary

Current Discharge Summary

Add New Document

Clinical Documents (12)

- Clinical Notes - Admission N
- Clinical Notes - Medication H
- Clinical Notes - Medication F
- Discharge Summaries (5)

EKG (3 / 3)

- 24-Apr-2006 EKG Michael V
- 22-Apr-2006 EKG Michael V
- 25-Nov-2002 EKG Michael V

Inpatient Referrals (1 / 1)

- General Medicine Clinic (1)

Laboratory (35 / 40)

- Blood Gases (1 / 1)
- Chemistry (9 / 9)
- Hematology (19 / 24)
- Microbiology (4 / 4)
- Serology (1 / 1)
- Surgical Pathology (1 / 1)

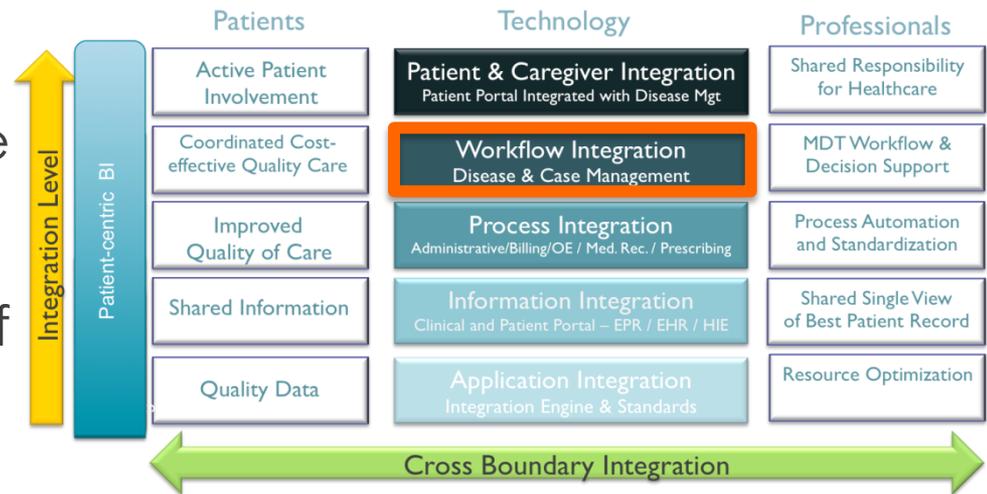
Outstanding Orders (2 / 2)

- Diabetes Clinic (1 / 1)
- Radiology (1 / 1)

Clinical Process

Workflow Integration

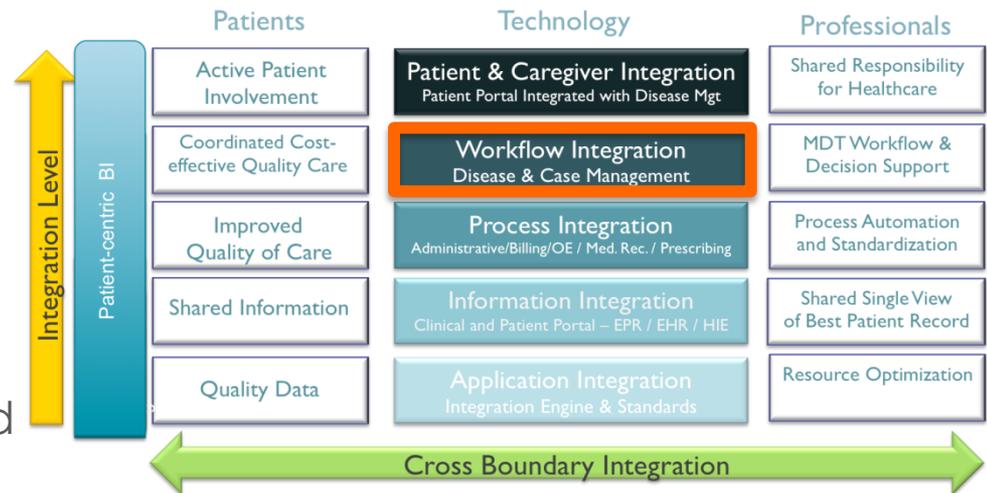
- ★ Can now address the big issues of chronic disease management, by coordinating care across the patient journey
- ★ Application that supports the complete continuum of care
 - ★ Patient centric
 - ★ Multi-disciplinary care teams
 - ★ Implements use of evidence based guidelines across the continuum of care
 - ★ Integrated clinical decision support
- ★ Better outcomes on a population basis



Workflow Integration

Care Management Tools

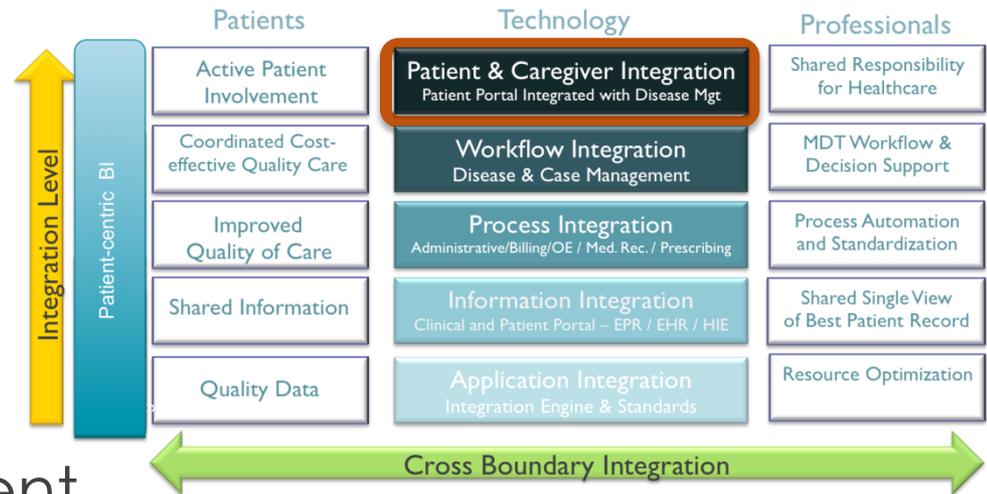
- ★ Care coordination and involvement of multi-disciplinary care teams
- ★ Clinical pathways that extend across silos of care
- ★ Shared care plans
- ★ Meaningful patient involvement including patient education and patient self management
- ★ Real-time clinical data accessed and captured at the point of care
- ★ Integrated clinical decision support



Clinical Process

Patient Integration

- ★ More engaged, self managing population
- ★ Remote monitoring
- ★ Patient self management education



Making Patients (and Circle of Care) part of Care Delivery Team

- ★ Patient portals need to be sophisticated yet simple if Patients and families are to effectively use them
- ★ Patients change their behavior when they see a path to better health
- ★ Patients need feedback on how they are doing

Select Patient
You have access to multiple patients. Please select the patient you would like to view.

Patient *

Your Test Results

NAME: Cora Peterson
GENDER: Female
AGE: 41
DOB: August 12, 1969
ORDERED BY: Dr. Pico Duval

COLLECTED: November 13, 2010, 8:40 a.m.
RECEIVED: November 13, 2010, 8:12 p.m.

Your results at a glance:

- YOUR GLUCOSE LEVELS ARE TOO HIGH, WHICH INDICATES PREDIABETES.
- YOUR VITAMIN D LEVEL IS TOO LOW.
- YOUR CHOLESTEROL LEVELS ARE BORDERLINE HIGH.
- YOUR KIDNEY, LIVER, AND THYROID FUNCTION ARE ALL NORMAL.

Questions?
Contact the physician who ordered this test for further interpretation of the results.
DR. PICO DUVAL
(212) 555-5053

RESULTS:

Comprehensive Metabolic Panel
Glucose (fasting): 125 mg/dL

NORMAL	PREDIABETES	MAY INDICATE DIABETES
< 100	100 to 125	> 125
		YOU: 125

Vitamin D
Total vitamin D: 22 ng/mL

DEFICIENCY	INSUFFICIENCY	SUFFICIENCY
< 20	20 to 30	31 to 100
		YOU: 22

Complete Blood Cell Count (CBC) Normal for all 20 values, including white blood cell count (a high count can indicate infection).

Urinalysis Normal for all 20 values, including color, appearance, and protein.

Endocrinology Normal for TSH, which is an indicator of thyroid function, and for microalbumin and creatinine, measures of kidney function.

Chemistry Normal for iron, transferrin saturation, and ferritin. (Abnormal levels could indicate anemia, hepatitis, or other problems.)

Lipid Profile
Total cholesterol: 211 mg/dL

DESIRABLE	BORDERLINE	HIGH
< 200	200 to 240	> 240
		YOU: 211

HDL ("good" cholesterol): 46 mg/dL

LOW	NORMAL
< 50	> 50
	YOU: 46

LDL ("bad" cholesterol): 165 mg/dL

NEAR OPTIMAL	OPTIMAL	BORDERLINE	HIGH	VERY HIGH
< 100	100 to 125	130 to 155	160 to 190	> 190
				YOU: 165

Triglycerides: 160 mg/dL

OPTIMAL	BORDERLINE	HIGH	VERY HIGH
< 150	150 to 199	200 to 500	> 500
			YOU: 160

WHAT DO YOUR RESULTS MEAN?

- ELEVATED GLUCOSE:** The relatively high amount of sugar in your blood is typical of a patient with prediabetes, which can double your risk for heart disease, depending on other risk factors. See diabetes.org for more information.
- ELEVATED CHOLESTEROL:** Your relatively high cholesterol (a waxy substance produced in the liver) may also increase your risk of heart disease, depending on other risk factors. See heart.org for more information.
- LOWER LEVELS OF VITAMIN D:** Your results suggest insufficient vitamin D, which promotes bone density and immunosystem function. Women who fit your profile can become deficient within five months if no action is taken. Vitamin D deficiency may increase your risk for osteoporosis, high blood pressure, and certain cancers.

WHAT CAN YOU DO?

- CONSIDER YOUR LIFESTYLE.** If you are inactive, overweight, and/or a smoker, your risk for diabetes and heart disease rises. Exercising regularly (30 minutes/day) and reducing your weight by 5 to 10 percent lowers your risk of diabetes by 58 percent.
- ADDRESS OTHER RISK FACTORS FOR DIABETES AND HEART DISEASE.** Dietary changes, like reducing alcohol consumption and increasing fruit and vegetable intake, can decrease your cholesterol and triglyceride levels.
- ASK YOUR DOCTOR ABOUT REDUCING YOUR HEART DISEASE RISK.** Medications like statins can lower cholesterol and delay the onset of heart disease. Calculate your risk at go2010.rhlfh.net/ajpi/taclafdr.asp
- CONSIDER LIFESTYLE CHANGES TO CORRECT VITAMIN D INSUFFICIENCY.** These include diet, vitamin D supplements, and more exposure to sunlight.

Dashboard Reporting

- ★ Clinical quality and outcomes presented in real time

A1C

Important: Note that the data in this report comes from the Health Laboratory repository only.

A1C (by Provider)

Category	Patient Count
< 7.0	1
7.0-8.4	2
> 8.4	1
To Be Reviewed	9
Not Available	5

Provider: HULL, ALLEN
Chronic Condition: All
Total Number of Patients: 18

[Trend](#) [Printer friendly version](#)

Blood Pressure

Blood Pressure (by Provider)

Category	Patient Count
< 130/80	4
130-140/80-90	2
141-160/91-100	1
161-180/101-110	0
> 180/110	1
To Be Reviewed	1
Not Available	9

Provider: HULL, ALLEN
Chronic Condition: All
Total Number of Patients: 18

[Trend](#) [Printer friendly version](#)

BMI

BMI (by Provider)

Category	Patient Count
< 18.5	3
18.5-24.9	4
25-30	5
> 30	3
To Be Reviewed	0
Not Available	2

Provider: HULL, ALLEN
Chronic Condition: All
Total Number of Patients: 18

[Trend](#) [Printer friendly version](#)

Alberta Health Services

Edmonton/Calgary, Alberta, Canada

CUSTOMER OVERVIEW

- Chronic Disease Management (CDM) solution
- CDM has been a key strategic initiative since 2002
- Population of 3.7 million
- 117,000 employees
- More than 60,000 patients enrolled on CDM pathways

CHALLENGES/OPPORTUNITIES

Alberta Health Services required an Chronic Disease Management (CDM) solution to improve the clinical outcomes for patients living with chronic conditions and to reduce the cost of managing the long term care for these patients.

ORION HEALTH SOFTWARE COMPONENTS

- Clinical Portal
- Medical Templates
- Disease Management

DISEASE MANGEMENT PROGRAMS

- 25 pathways at Calgary Health, two pathways at Capital Health and two pathways Alberta-wide
- Pediatric (Type 1) Diabetes, Gestational Diabetes, Adult (Type 2) diabetes, Anti-coagulation, Living well (Stanford program for living with a chronic disease), Hypertension, Dyslipidemia, Atrial fibrillation, Community management of chronic disease



RESULTS

The Chronic Disease Management model of care in Alberta Health Services – Calgary area has been effective in improving clinical outcomes and likely has significantly reduced acute care utilization.

- 19,735 fewer bed days in one year period @ \$855-\$1600 = \$16.9 – 31.6M
- Current annual penetration into chronic disease population » 7%*
- Potential cost avoidance if 100% annual penetration » \$240-450M
- Estimated penetration since CDMIS inception = 25-30%
- 34% reduction in ER visits
- 42% reduction in ER visits with Asthma
- 31% reduction in - client bed days
- 16% improvement in A1c (diabetics)
- 12% improvement in cholesterol

Summary

Now is the time to:

- ★ Collaborate with stakeholders to leverage our experience and assets we have invested in previously
- ★ Work to develop agnostic integration that can equally impact stakeholders
- ★ Utilize the tremendous improvements in technology to ensure that new models for DM can be successful
- ★ Create a level of transparency that develops trust and engagement across all stakeholders



Questions

Final Thoughts



Thank You to Our Speakers

- Dr. Kate Lorig, Director, Stanford Patient Education Research Center
- Peggy Denness, MSW, Client Manager, Orion Health
- Dr. Chris Hobson, Chief Medical Officer, Orion Health



Slides/Recording for Sale

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 - eHI Store
 - <http://www.ehealthinitiative.org/store.html>



Take Advantage of eHI Resources

■ Upcoming Conferences

- 2012 eHI Annual Conference – Cancer, Diabetes and Heart Disease: Improving Care Through eHealth
 - January 11 and 12, 2012 - Washington, D.C.

■ Upcoming Webinars

- *Private Health Information Exchange: Enterprise and Proprietary Data Exchange*
 - Thursday, December 1, 2011

■ Reports and Directories

- Vendor Report
- List of HIEs and Selected Vendors
- Sustainability Report



Contact Information

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 - info@ehealthinitiative.org
- Jobs, fellowships, internships
 - jobs@ehealthinitiative.org



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