IBM Watson Health

Promises of Data-Driven Health and Care

Update on Population Health Management

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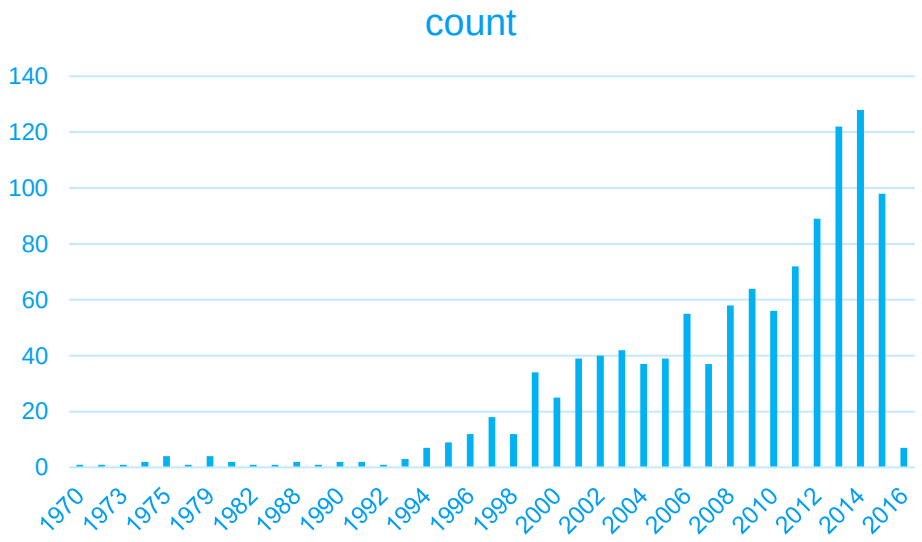
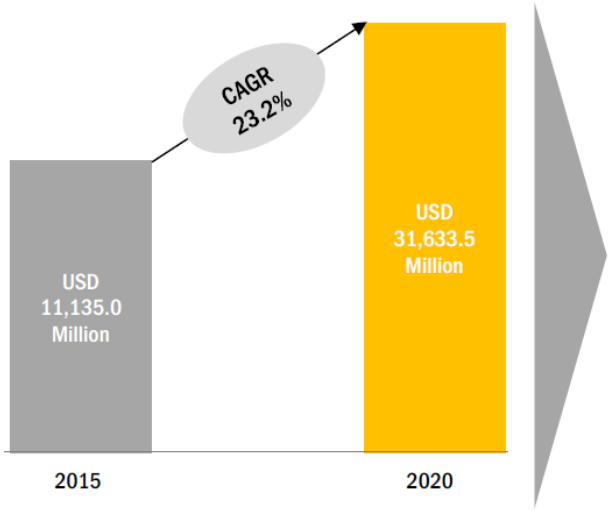


Pubmed search: title ‘population health’, + species = human. English language.

4.1 POPULATION HEALTH MANAGEMENT - MARKET OVERVIEW

FIGURE 12 IMPLEMENTATION OF THE AFFORDABLE CARE ACT (ACA) IN THE U.S. IS DRIVING THE GROWTH OF THE POPULATION HEALTH MANAGEMENT MARKET

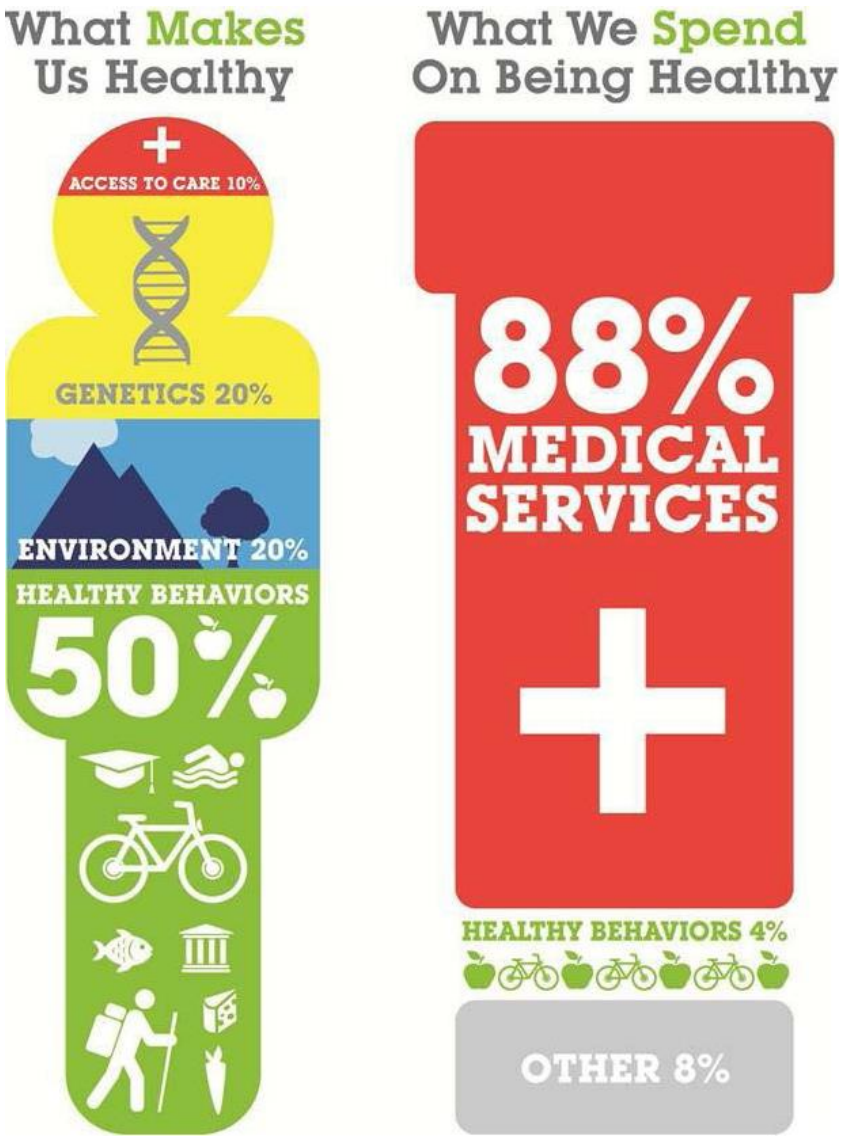


MARKET OVERVIEW

- The global population health management market is projected to reach **USD 31,633.5 million** by 2020
- Market growth is attributed to the **implementation** of the **Affordable Care Act (ACA), incentives and investments by the federal government for the adoption of HCIT, rising aging population, and increasing prevalence of rising chronic disease cases**
- **North America** is expected to account for the largest share—83.8%—of the population health management market in 2015
- **North America** is poised to be the fastest-growing market, growing at a **CAGR of 23.5% from 2015 to 2020**

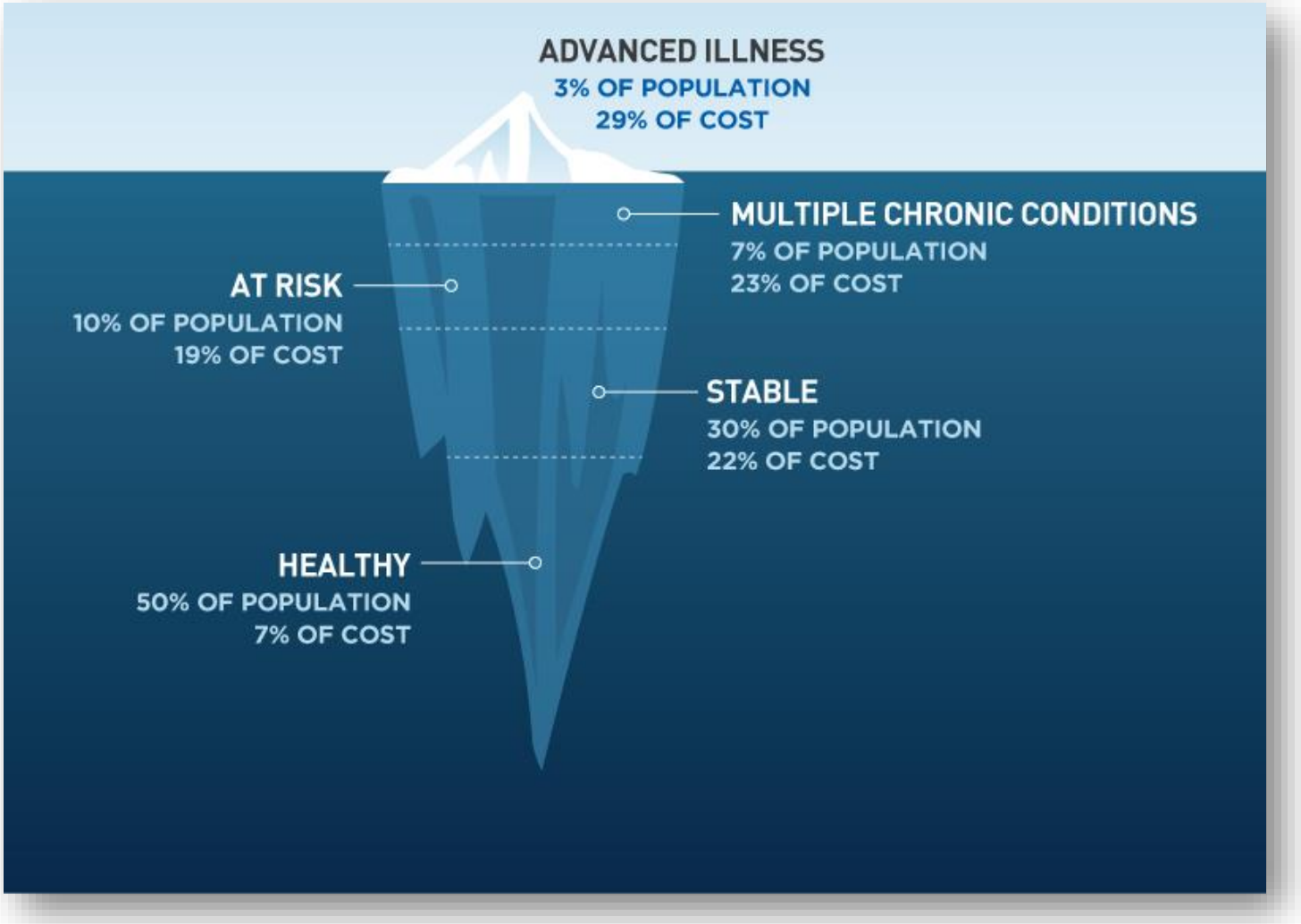
Source: Center for Population Health Sciences, The Institute for Health Technology Transformation (iHT2), Healthcare Information and Management Systems Society (HIMSS), American Medical Group Association (AMGA), International Association of Health Policy (IAHP), Institute of Population Health (University of Manchester), Institute of Population and Public Health (IPPH), Public Health Agency of Canada, Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (CNAMTS) (France), Expert Interviews, and MarketsandMarkets Analysis

Population Health Management Market, Analysis and Global Forecasts to 2020. Markets and Markets



Source: Bipartisan Policy Center, "F" as in Fat: How Obesity Threatens America's Future (TFAH/RWJF, Aug. 2013)

Focusing on sickest does not bend the cost trend

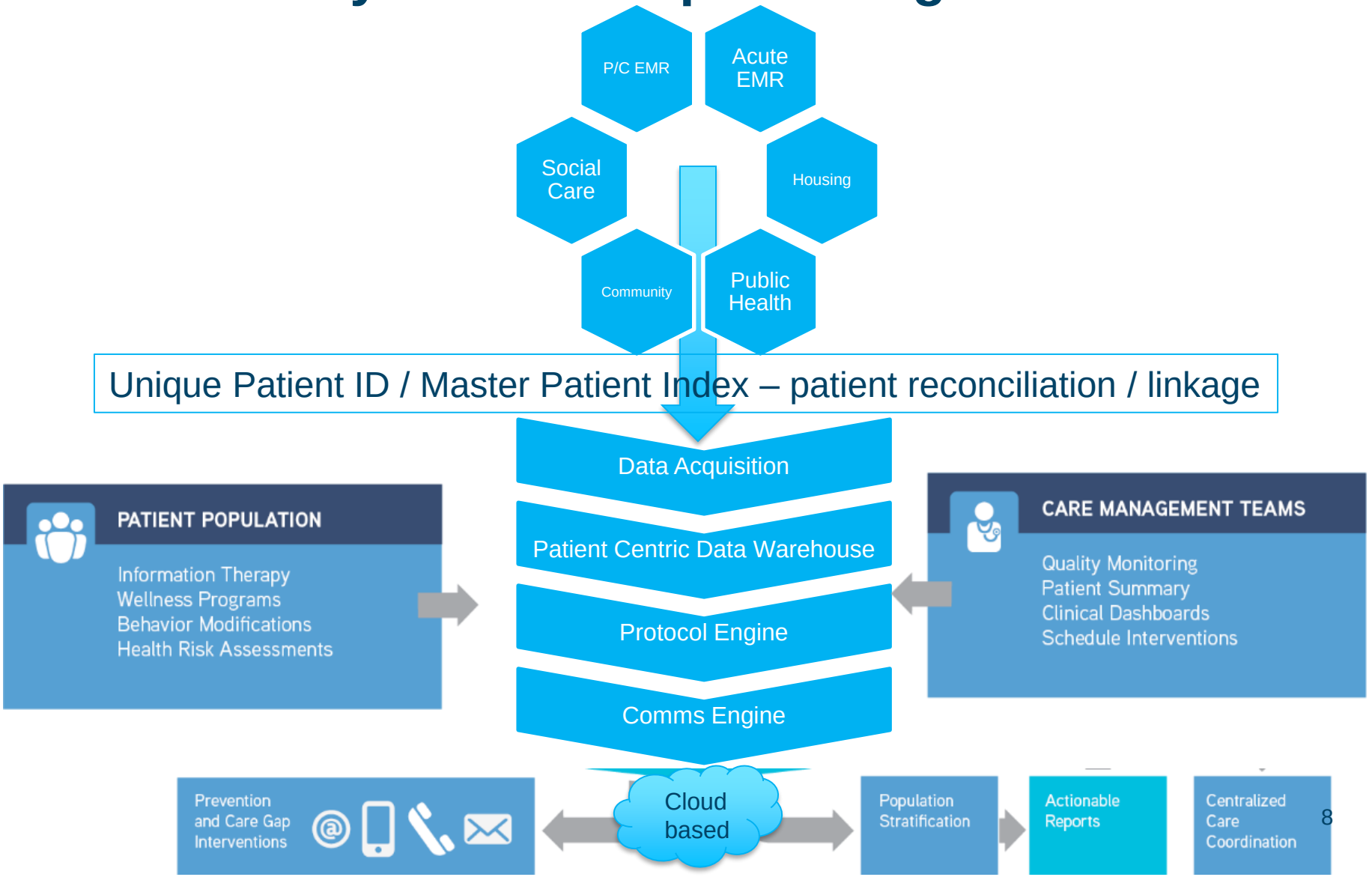


Spot the 'patient'…

Key facets of population health management

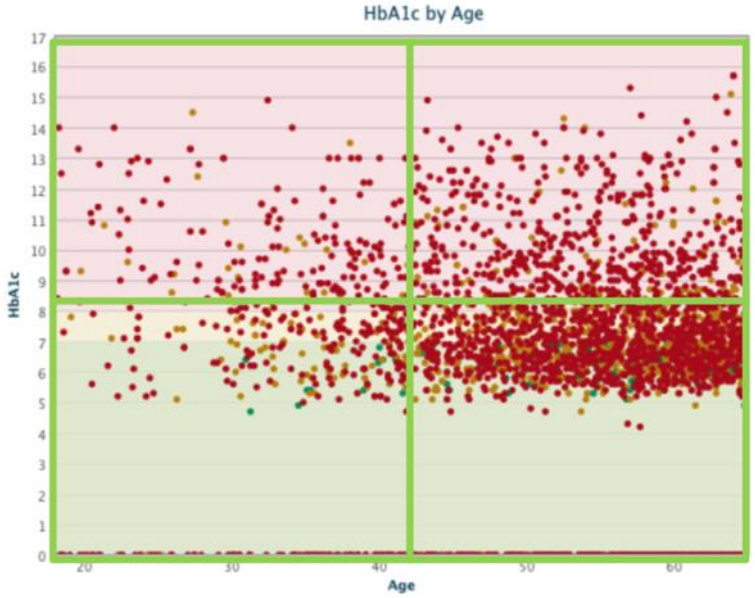
- Substantial use of data
- Comprehensive view of ‘health’ – physical, mental, whole person
- Early Intervention, Health Promotion and Prevention
- Wider determinants of health considered – eg Income maximisation, legal advice, housing, education
- Addressing lifestyle behaviours
- Population stratification / risk prediction
- Care pathways defined and used, automated management
- Self-management
- Integration across agencies & team based care

New delivery models require integrated data…



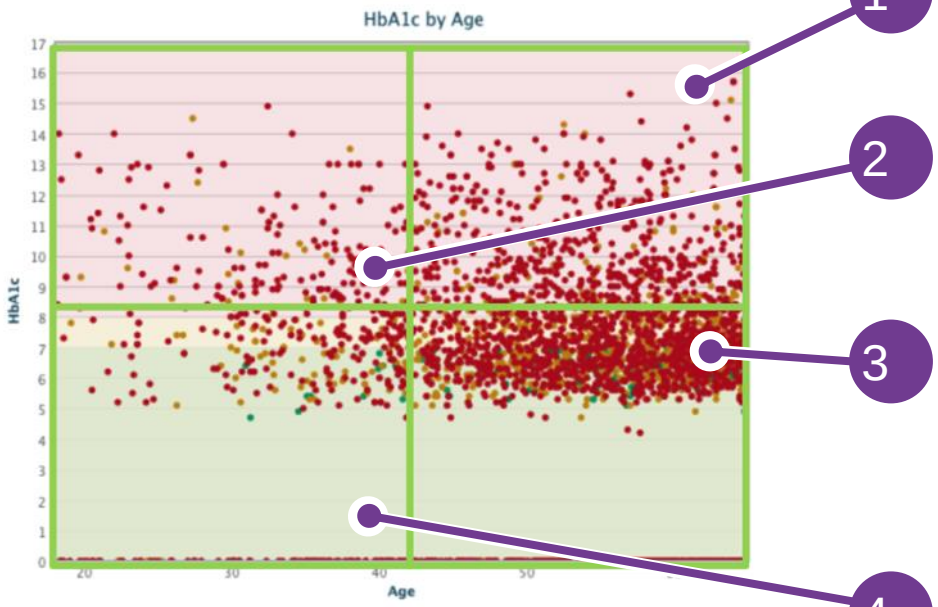
Taking Action on “Actionable Data”

Understand the population:



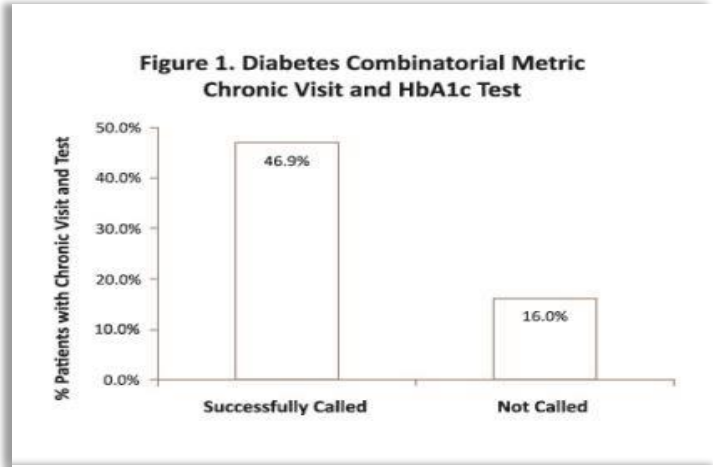
Taking Action on “Actionable Data”

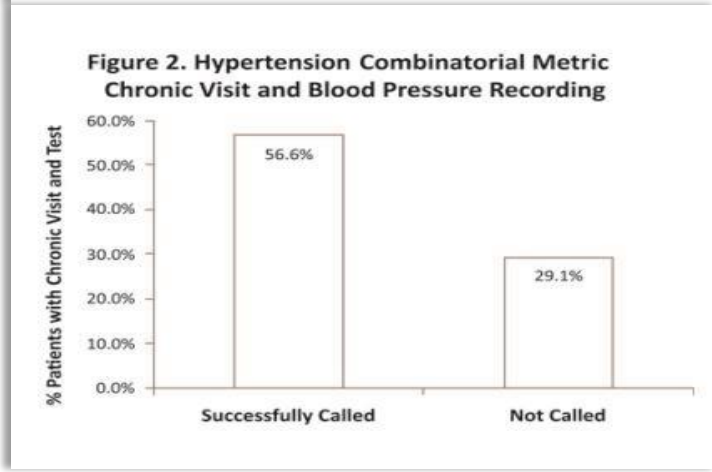
Address entire population with targeted interventions



1. All >9 A1c and no planned GP visit are sent a text message to call care manager
2. All >9 and BMI >35 are sent an automated invitation to a group visit with a diabetes dietician
3. All between A1c 7 and 9 are sent an automated message to encourage visit website to take diabetes self-management course
4. All diabetics <7.0 are sent an email message emphasizing the importance of nutrition and exercise to maintain low A1c levels with a link to a mobile app to track their progress

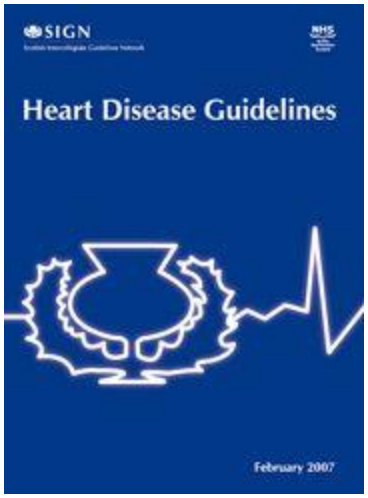
Bring people into the system (appropriately)





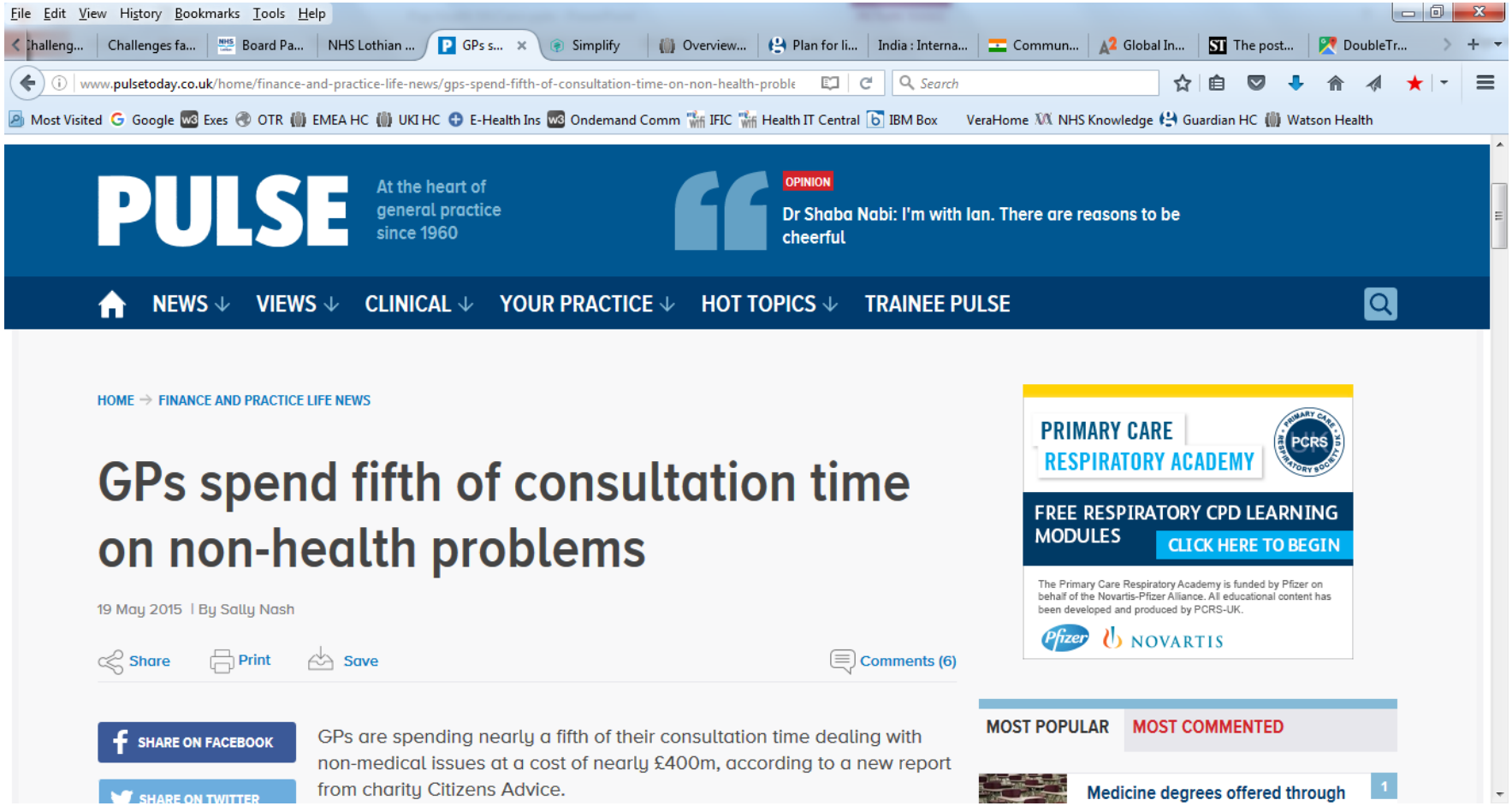
Automate

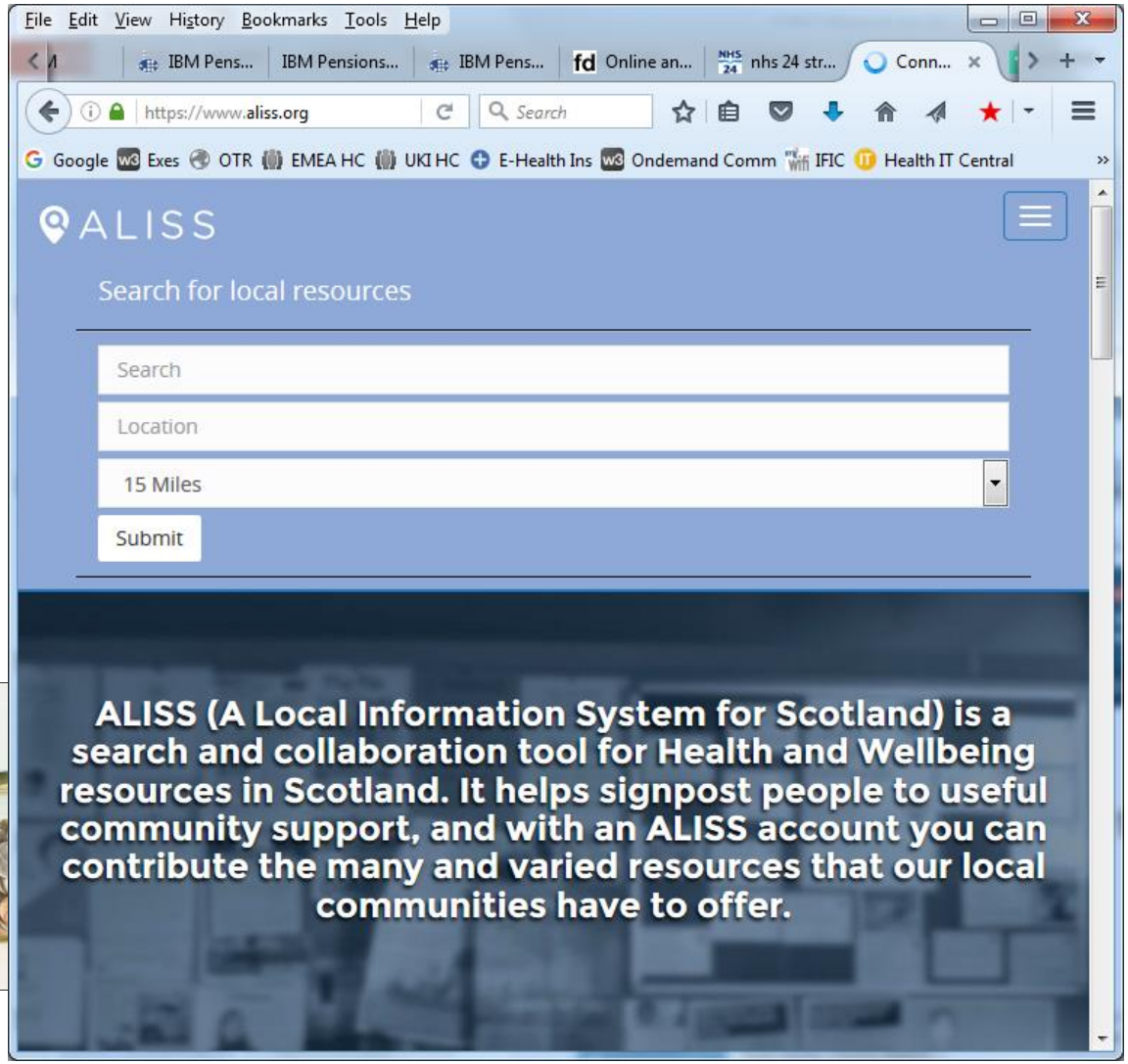
NICE National Institute for Health and Care Excellence



Patient engagement / self management

Comprehensive view of ‘health’ / wider determinants

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E-Health Ins
Ondemand Comm
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ALISS
Search for local resources
Search
Location
15 Miles
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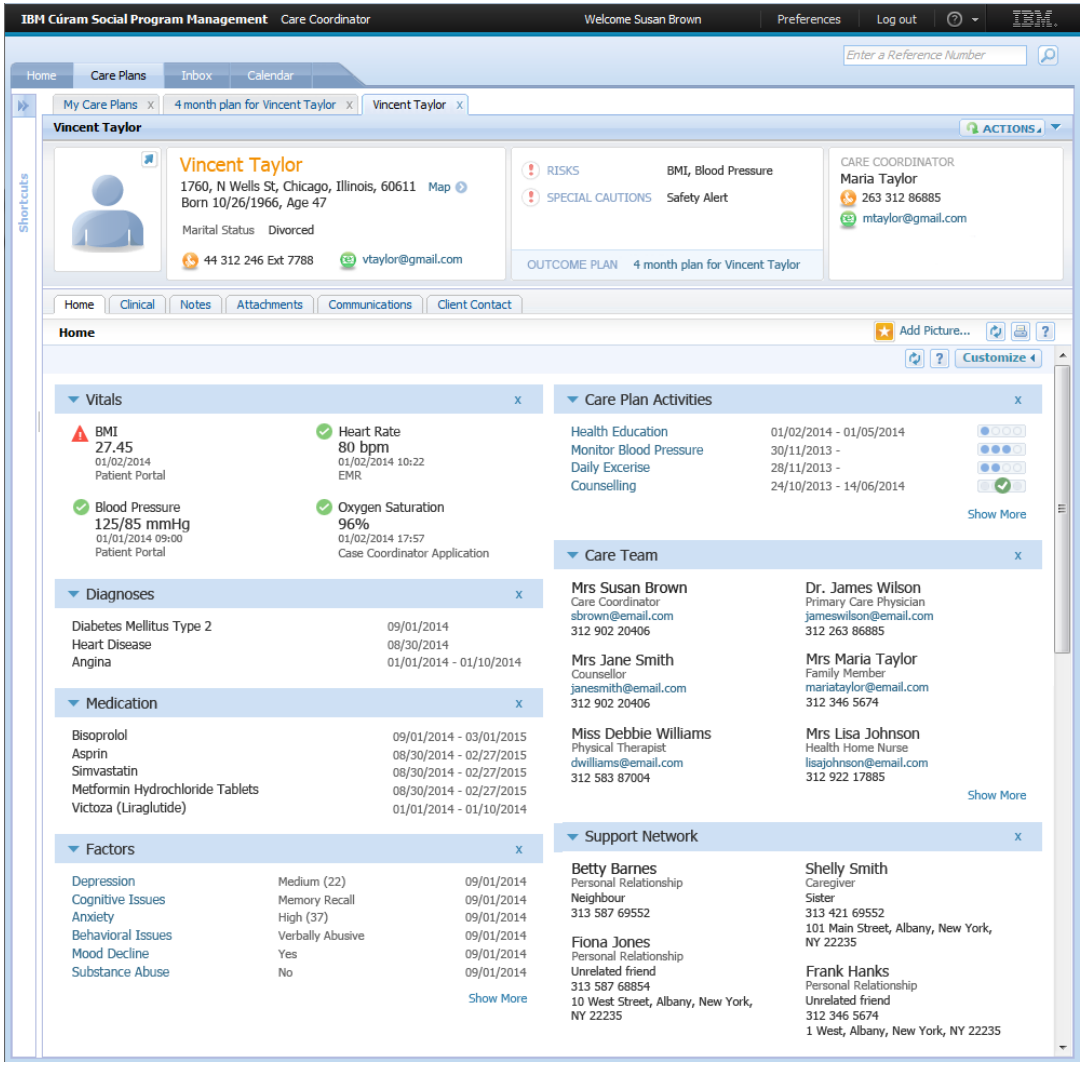
ALISS (A Local Information System for Scotland) is a search and collaboration tool for Health and Wellbeing resources in Scotland. It helps signpost people to useful community support, and with an ALISS account you can contribute the many and varied resources that our local communities have to offer.

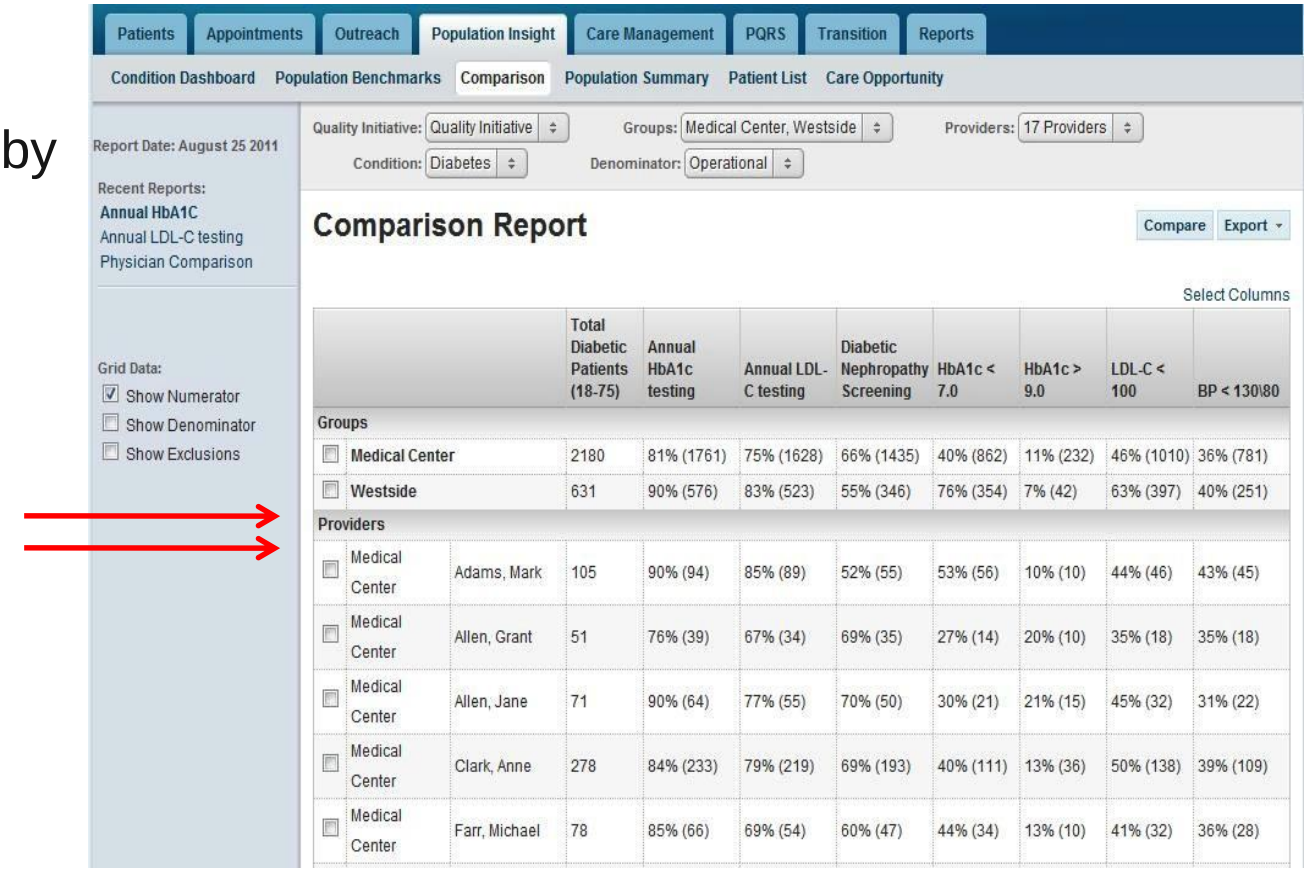
Team based care – integrated across agencies



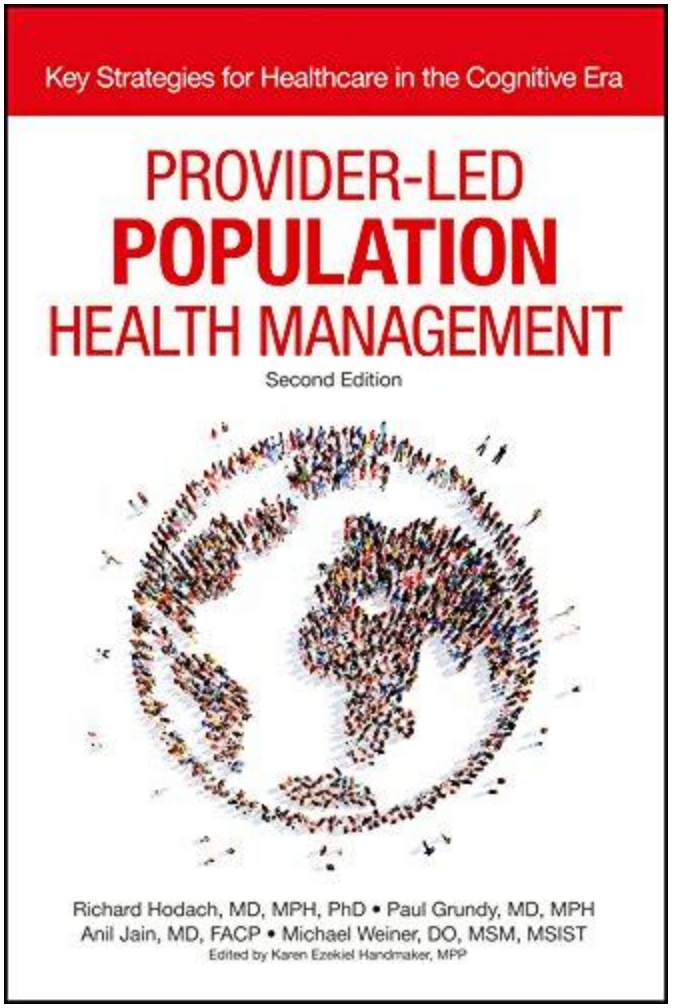
System Comparison

eg Identify variance in care by practice

Identify variances by practice to target improvement strategies



			Total Diabetic Patients (18-75)	Annual HbA1c testing	Annual LDL-C testing	Diabetic Nephropathy Screening	HbA1c < 7.0	HbA1c > 9.0	LDL-C < 100	BP < 130\80
Groups										
	Medical Center		2180	81% (1761)	75% (1628)	66% (1435)	40% (862)	11% (232)	46% (1010)	36% (781)
	Westside		631	90% (576)	83% (523)	55% (346)	76% (354)	7% (42)	63% (397)	40% (251)
Providers										
	Medical Center	Adams, Mark	105	90% (94)	85% (89)	52% (55)	53% (56)	10% (10)	44% (46)	43% (45)
	Medical Center	Allen, Grant	51	76% (39)	67% (34)	69% (35)	27% (14)	20% (10)	35% (18)	35% (18)
	Medical Center	Allen, Jane	71	90% (64)	77% (55)	70% (50)	30% (21)	21% (15)	45% (32)	31% (22)
	Medical Center	Clark, Anne	278	84% (233)	79% (219)	69% (193)	40% (111)	13% (36)	50% (138)	39% (109)
	Medical Center	Farr, Michael	78	85% (66)	69% (54)	60% (47)	44% (34)	13% (10)	41% (32)	36% (28)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Population Health Management - one person at a time

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