Promises of Data-Driven Health and Care

Update on Population Health Management

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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 Travaillleurs Salariés (CNAMTS) (France), Expert Interviews, and MarketsandMarkets Analysis.
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…

Unique Patient ID / Master Patient Index – patient reconciliation / linkage

DATA ACQUISITION

P/C EMR
Acute EMR
Social Care
Housing
Community
Public Health

DATA ACQUISITION

Patient Centric Data Warehouse
Protocol Engine
Comms Engine

PATIENT POPULATION
Information Therapy
Wellness Programs
Behavior Modifications
Health Risk Assessments

CARE MANAGEMENT TEAMS
Quality Monitoring
Patient Summary
Clinical Dashboards
Schedule Interventions

Prevention and Care Gap Interventions
Population Stratification
Actionable Reports
Centralized Care Coordination
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

GPs spend fifth of consultation time on non-health problems

19 May 2015 | By Sally Nash

GPs are spending nearly a fifth of their consultation time dealing with non-medical issues at a cost of nearly £400m, according to a new report from charity Citizens Advice.
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
Identify variances by practice to target improvement strategies
Population Health Management
- one person at a time

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