In today’s value-based healthcare environment, investing in technology to meet the demands of population health management (PHM) and achieve the goals of the Institute of Healthcare Improvement (IHI)’s Triple Aim has become increasingly important.

Successfully achieving the Triple Aim

How five healthcare organizations utilized data and technology to lower costs, close care gaps and improve patient care

Overview

The need
Five organizations sought tools and strategies that could help them use their data to improve care, lower costs and engage patients

The solution
These five clients implemented IBM Watson Health™ solutions to significantly improve their PHM programs

The benefit
Each of these clients created a high-performing PHM program to help promote better health outcomes, drive revenue and improve quality metrics
IBM® Phytel® and IBM® Explorys® solutions, provided by IBM Watson Health™, offer PHM solutions that can help clients manage patients across the continuum of care, including technology for patient engagement, performance management, care coordination, discharge follow-up and patient self-management.

This case study highlights how IBM Watson Health solutions have helped clients successfully achieve improved patient care, drive revenue and simplify alignment with quality measures and initiatives.

Financial
Healthcare organizations at different levels of PHM maturity are finding ways to generate extra revenue from their efforts to advance their PHM program.

Orlando Health
- Generated $6.6 million in shared savings in 2013 from two accountable care organization (ACO) contracts (all reporting to the Medicare Shared Savings Program (MSSP) is provided through IBM Phytel)

Utica Park Clinic
- Pilot program generated more than $840,000 in additional billable revenue
- Achieved total return on investment of 14:1

Hallmark Health
- Increased revenue by approximately $2 million as a result of appointments booked through automated outreach
Care gaps
Now, healthcare organizations can scale care management with the use of patient engagement tools that utilize protocol-driven, patient-centered registries to automatically identify care gaps and trigger messages to patients for recommended care.

Orlando Health
- Percentage of all 270,000 targeted patients who closed a care gap increased by 22 percent in the first year

Prevea Health
- 207 percent increase in office visits by noncompliant diabetics
- 124 percent more office visits by Phytel-contacted hypertension and diabetes patients

Utica Park Clinic
- Initiated 291,426 patient communications for appointment reminders and care gap closure
- Patients successfully reminded of almost 140,000 appointments
- Nearly 65,000 patients were informed of an identified gap in care
- More than 6,800 patients were spurred to interact with Utica Park Clinic providers to close care gaps

Quality
The shift from fee-for-service to value-based care has put an increased emphasis on all aspects of quality improvement. We believe the aggregation of clinical data is vital to evaluate and measure an organization's effectiveness.

Prevea Health
- 250 percent improvement in care management efficiency

Mercy Health Select, LLC
- Achieved a 5.7 percent higher ACO overall quality score as compared to the MSSP average

Patient care
Patient engagement, data management, risk stratification, care management, and quality measurement are essential to improving patient care. By using its data effectively, an organization can scale its efforts and meet this key dimension of the Triple Aim.

Orlando Health
- Percentage of diabetic patients who have a current HbA1c test increased by 7 percent in the first year
- Percentage of all adult female patients receiving preventive mammogram screenings increased by 10 percent in the first year
- Percentage of all patients over 50 years of age receiving preventive colonoscopy screenings increased by 9 percent in the first year
- Percentage of elderly patients receiving falls-risk screening increased by 15 percent in the first year
- Percentage of patients who received depression screening and a follow-up plan increased by 10 percent in the first year
Solution components

- IBM Phytel Coordinate
- IBM Phytel HCC Risk Manager
- IBM Phytel Outreach
- IBM Phytel Patient Engagement
- IBM Phytel Remind
- IBM Phytel Transition
- IBM Explorys Platform
- IBM Explorys EPM: Measure

About IBM Watson Health

Each day, professionals throughout the health ecosystem make powerful progress toward a healthier future. At IBM Watson Health, we help them remove obstacles, optimize efforts and reveal new insights to support the people they serve. Working across the landscape, from payers and providers to governments and life sciences, we bring together deep health expertise; proven innovation; and the power of cognitive computing to enable our customers to uncover, connect and act — as they work to solve health challenges for people everywhere.

For more information on IBM Watson Health, visit: ibm.com/watsonhealth.

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