Amplify primary care efficiency, profitability and quality with Population Health

Primary Care Providers (PCPs) are the directors of their patients' entire healthcare journey, laying out the game plan for patients' visits, tests, diagnoses and treatments. What's more, the best PCPs work to avert disease progression with proactive preventive care. But there isn't enough time in the day – increasing documentation requirements, decreasing fee-for-service payments along with the shift to value-based care require PCPs to work smarter with their team.

GE Healthcare is here to help PCPs extend their reach and work efficiently. Our innovation is combining tools into a single solution designed for PCPs – comprehensive care delivery, financial management, population health, patient engagement, analytics, and connectivity.

The population health component of our PCP solution gives visibility to all patients by risk profile so you can make sure your patients engage in the care they need and optimize the value of the care you deliver. The goal is to boost the quality of care at your facility, improve profitability and leave your patients feeling satisfied with the one-on-one interaction they've come to expect. By delivering informed care more efficiently than with an EMR alone, you can more effectively build your business and enjoy practicing again.

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Population Health Benefits

Prioritize patients for intervention

Easily visualize patients with gaps in care and group them with others who share similar health issues and prioritize groups for intervention.

Efficiently manage populations

Develop condition-specific care plans, apply them to the appropriate population, and efficiently manage activities for the entire group.

Coordinate across the care team

Role-based workflows enable more efficient execution of patient specific care plans and easy collaboration with other members of the care team.

Deliver thorough, consistent care

Point-of-care decision support, incorporating data and evidence-based guidelines, helps you consistently close gaps in care during the visit.

Capture value-based payments

Optional pre-defined programs help deliver success in chronic care management and transitional care management.

Increase Provider Efficiency

Optimize team care activity – Ensure that care team members are assigned tasks most suited to their skills so everyone practices at the top of their license.

Extend provider reach – Free physicians from task delegation and more on active care.

Easily access population health capabilities – Reduce clicks and streamline the clinical workflow with capabilities embedded directly within the native EHR.

Accelerate the process for closing gaps – Notify providers of care gaps automatically and streamline communication with patients experiencing gaps.

Strengthen Financial Performance

Drive additional fee-for-service revenue – More easily identify and close gaps in care to better serve your patients and support financials.

Optimize contribution of staff – Improve staff return on investment by enabling care teams to practice at the top of their license.

Supplement payment for care delivered – Leverage optional components to earn payment for management of chronic illnesses or transitions in care settings.

Enhance Care Quality

Identify patients most in need of intervention – Stratify patient populations by risk, clinical and financial characteristics and optimize care team activity.

Customize when needed – Care plans can be tailored for individuals if needed, fostering customized care.

Use evidence-based care as the standard – Reference the latest guidelines for the treatment of specific conditions and use these standards to build care plans.

Drive improvement with insights – Track quality metric performance and then drill down by site, provider, or patient to identify actionable insights.

Accelerate Your Transition to Value-Based Care

Better manage chronic conditions – With evidence-based care plans, you can drive improved outcomes for the most prevalent diseases and conditions.

Prioritize care delivery – Patients who need the most, get the most.

More easily achieve incentives – Set quality goals consistent with incentive payments, visualize progress to goals, and easily report on key metrics such as HEDIS and ACO.

Join us for the journey

Our new IT solution for PCPs is just the beginning of our commitment to you. It is the first step in an evolution into a comprehensive, fully integrated, interoperable and intelligent cloud-based software solution that will combine decades of healthcare expertise with cutting-edge capabilities and a modern user experience. One that puts patients where they belong – at the center of care. One that only GE can deliver.

86% of patients
at highest risk saw improvements in LDL goal attainment[1]

Added ~400K
in incremental annual revenue[2]

Engaged patients
through health literate information and tools[3]

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1. "A Randomized Controlled Trial of Team-Based Care: Impact of Physician-Pharmacist Collaboration on Uncontrolled Hypertension", by Jacquelyn S. Hunt, Pharm D MS, Joseph Siemienczuk, MD, Ginger Pape, Pharm D, Yelena Rozenfeld, MPH, John MacKay, Pharm D, Benjamin H. LeBlanc, MD MBI, and Daniel Touchette, Pharm D MA, Journal of General Internal Medicine, December 2008
2. **Source:** Center for Primary Care, chronic care management study
3. **Source:** Central City Concern diabetes management study

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