HealthCatalyst

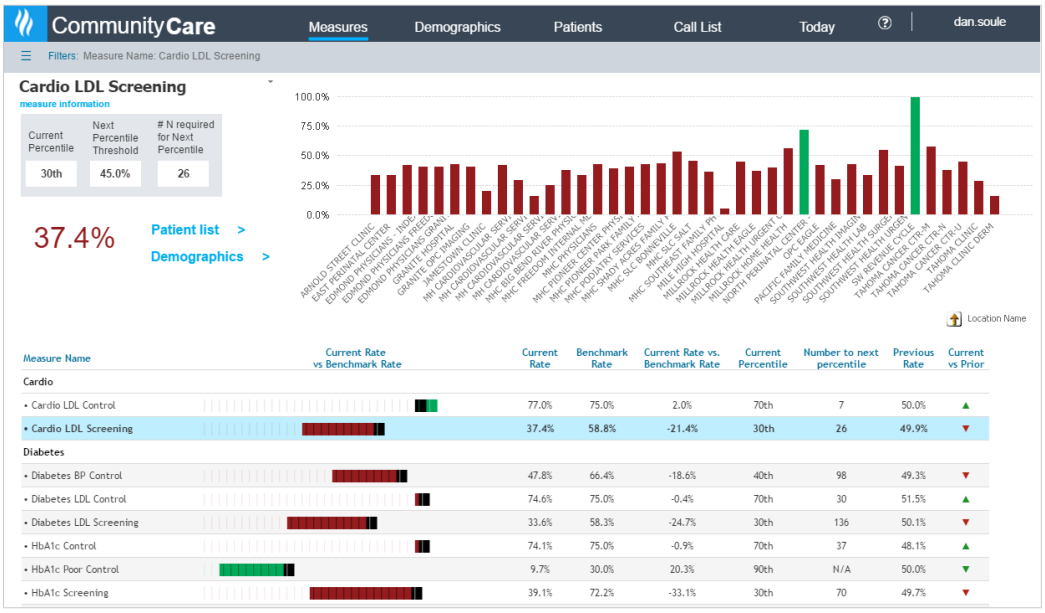
Community Care

Actionable analytics to close gaps in primary and preventive care—helping you deliver the right care at the right time to every patient

Type: Analytics Accelerator **ID:** 1478 **Revised:** 2019-11-15

The **Community Care** analytics accelerator provides data and visualizations to enable best-practice care of patients in ambulatory settings—supporting teams in their efforts to improve preventive care, better support patients with chronic conditions, and understand and manage performance against population health quality measures.

Note: Like all analytics accelerators, this application is implemented in a custom way. Organizations identify their own areas of focus—and the appearance and functionality of the accelerator may differ from what is presented here.



The Community Care accelerator drives improvement in preventive and primary care—making it easier to close care gaps and improve performance against quality measures.

The problem

- **The prevalence of chronic conditions is high and increasing.** The model of acute, episodic care does not meet the needs of patients with chronic conditions, leading to gaps in care and poor outcomes.
- **The cost burden of chronic disease is substantial.** Between 75% and 85% of U.S. healthcare costs are attributable to patients with chronic diseases.
- **Better identification of patients with high-risk, high-cost chronic conditions improves outcomes** . Research also links patient-centered community care to improved physician-patient communication and relationships, higher patient satisfaction, better recall of medical information, and treatment adherence.
- **Providers and clinic staff often struggle to see and meet patient needs.** Problem lists rarely have the information providers need to plan visits and coordinate care.

Intended users

- Chief Analytics Officer
- Chief of Population Health or the ACO
- Chief Quality Officer
- Chief Information Officer
- Primary care leadership, providers
- Care coordinators working in ambulatory settings
- Quality improvement teams
- Staff responsible for reports related to the organization's status as an Accountable Care Organization (ACO)

Potential data sources

- EMR - Clinical
- Patient Satisfaction
- Claims
- Quality value sets (e.g., HEDIS)
- QRD files exported from EMR systems

Our approach

The Community Care analytic accelerator enables a proactive approach to ambulatory care, helping providers identify patients' current and rising needs, schedule outreach to specific patients, coordinate care across sites and providers, and easily see what screening, monitoring, and therapies are needed during primary care visits. At an organizational level, the application allows leaders and managers to identify population health risks, compare performance to national benchmarking standards, identify opportunities for costs savings, and help practices track, monitor, and meet the needs of high-risk patients.

Benefits and features

- **Identify—and address—gaps in care, especially for your high-risk patients.** The application makes it easy to track and manage the care of specific populations, e.g., those with diabetes, heart failure, hypertension, hypercholesterolemia, and other chronic conditions. Providers and organizations can identify gaps in care, gauge adherence to best-practice screening and care, and support appropriate and timely interventions.
- **Improve performance against quality measures.** The application allows you to add your own measures and measure groups, customized for your organization's quality reporting requirements—and by providing visibility into these and other selected measures (e.g., PQRS, ACO MSSP, HEDIS), the application supports accurate and efficient reporting on these measures and helps your teams identify and target areas for improvement.
- **Drive better coordination and a proactive approach to patient care.** Organizations can plan visits and referrals based on needs surfaced in the app (e.g., if you see that your patient with diabetes has an annual visit in 6 months, you can facilitate completion of an eye exam and blood work ahead of time). The app also allows you to identify people at risk for worsening health or development of chronic conditions (e.g., patients with prediabetes or at risk for heart failure) so you can plan interventions to prevent or slow progression.
- **Use performance benchmarking and patient-population data analysis to identify areas for care improvement** . Analyzing data at the system, clinic, and/or provider level can provide insights into performance relative to internal and external benchmarks. And, tracking high-risk patients supports care coordination across primary care and other community provider settings, helping reduce service duplication, operational and care costs, care disparities, and gaps in care delivery.

Use cases

- **A care coordinator** wants to identify patients with cardiovascular disease who have hypertension and high LDL; these patients will be the focus of new outreach efforts aimed at preventing an AMI.
- **A primary care provider** and **diabetes educator** want to gauge the impact of several new initiatives aimed at improving diabetes self-management. They're looking at HbA1c results based on diet classes and focused education.
- **An obstetrical provider** wants to see how many of her patients have been screened for chlamydia and other STIs.
- After a particularly brutal influenza season, **the leadership in a multispecialty clinic** wants to review immunization rates and patterns to help them design a community health campaign for the following year.
- **The ACO leadership** uses the application to watch for performance trends that may affect their success in at-risk contracts. They can answer questions such as, "Are we going to hit our quality reporting targets? Where are there gaps, and how large are the gaps?" (For example, the team might want to know how many patients they need to screen to hit their target.) The ACO leaders use Community Care insights to select priorities for improvement and guide interventions to improve.

Key measures

Adherence to guideline-directed primary and preventive care metrics (as per HEDIS, ACO MSSP, PQRS as identified), for example:

- **Lab results** with control indicators (e.g., LDL and HbA1c blood test results)
- **Vitals** with control indicators (e.g., blood pressure)
- **Diabetes** in control indicators (e.g., LDL, HbA1c, blood pressure, aspirin prescription, tobacco use)
- **Preventive** in control indicators (e.g., cervical cancer screening, mammogram, colonoscopy, STI screening, influenza and pneumococcal vaccination)

Success stories

For examples of how customers have used Health Catalyst products and services to improve outcomes, visit https://www.healthcatalyst.com/knowledge-center/success-stories/

Contact us

For more information on how Health Catalyst products and services can help your organization, please contact us:

- Reach out to your sales representative
- Call us at (855) 309-6800
- Email us at info@healthcatalyst.com