

Population Health Foundations Solution

TYPE	STATUS	REVISED
Solution Set	In-Development	2019-August-28

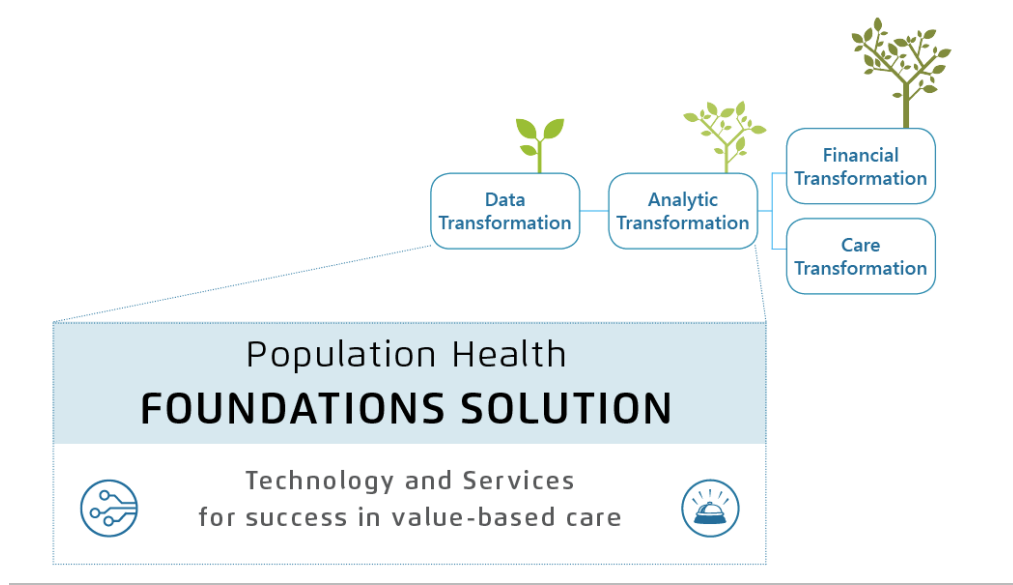
Technical Description

The **Population Health Foundations Solution** combines services with data and analytics technology to create a population health management (PHM) analytics starter set that can help organizations optimize their performance in value-based risk arrangements.

The technology components are **DOS™ Marts**, Excel-friendly **analysis tools** that provide direct access to data for custom analysis, the **Population Builder™: Stratification Module**, the **Leading Wisely: Population Health Module**, and the **Community Care Analytic Accelerator**.

Solution services consist of **Solution Optimization** and a Population Health Management (PHM) **Opportunity Analysis**. Together, the elements of Population Health Foundations represent an essential resource for organizations that face financial risk for managing the health of populations—bringing a depth and breadth of insight and guidance for short- and long-term success in value-based care.

Visualization



Population Health Foundations provides the intelligent tools and foundational analytics—plus expert, side-by-side guidance and support—to maximize the value of your data for success in value-based care

Population Health Foundations Solution

Background

The transition to value is now an imperative—but population health work can seem overwhelming and risky. And with inflexible, black-box point solutions, organizations continue to struggle to transform quality, cost, and delivery of care.

Overview

A guided—yet flexible—approach for value-based care success through foundational analytics applications and optimization services

Population Health Foundations is an accelerant to your organization's success in value-based care. A robust expression of the data-and analytics-first approach so essential for accommodating the breadth and complexity of population health needs, this solution provides the transparent, configurable platform, tools, and analytics that allow you to use your data however you need to scale and prioritize. As part of the solution, our deep bench of subject matter experts provides a side-by-side partnership to support your success whether your organization is new to population health or has years of experience.

The Population Health Foundations solution is a starter set for organizations to build upon based on their individual opportunities and goals. Health Catalyst's wide variety of PHM tools can stack on to this foundational solution to provide, for example, insights to HCC gaps and opportunities, care management workflow support, care variation opportunity identification, population benchmarking, and much more.

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Benefits and Features

- **Integrate your claims and clinical data—and transparently transform raw data to deep data for faster, better insight into your value-based care business.** DOS Marts aggregate, organize, and rationalize your claims and clinical data and give you a complete view of the care your patients are receiving across the continuum, and in and out of your network. The data flows seamlessly between the technology components of the solution, ensuring that your data, definitions, and population registries are diffused across your organization's PHM workflow.
- **Open up the black box with flexible, analyst-friendly tools.** With our Excel-friendly tools, your analysts have transparency into the data and an easy, extensible entrance to in-depth analysis.
- **Leverage intelligent tools to identify and stratify patients.** Population Builder: Stratification brings predefined populations, standard risk scores, and machine learning models—all of which can be customized to support your organization's needs for analysis, quality improvement, and reporting.
- **Empower executives with robust views of your quality and financial performance.** The Leading Wisely: Population Health Module gives you one place to access financial metrics for your value-based contracts and achieve a holistic view of performance. The module's out-of-the box content is easily configurable to focus on the financial KPIs that matter most to you—total cost of care, utilization in-and out-of-network, PMPM, etc. And because the information generated can be easily distributed via dashboard or static report, the application helps population health leaders create alignment among clinical and financial teams and communicate decisions clearly and quickly for downstream work.
- **Identify—and address—gaps in care .** Community Care Analytic Accelerator makes it easy to track and manage care at the individual patient and provider level. Providers and organizations can identify gaps in care and drill down to the patient level, gauge adherence to best-practice screening and care, and support appropriate and timely interventions.
- **Understand your data deeply to build short-, medium-, and long-term strategies for success.** Our PHM experts provide side-by-side guidance for data and analytics strategy, design, and implementation—maximizing your investment in data and technology to support achievement in your specific payer arrangements.

Population Health Foundations Solution

Technology within the Solution

- DOS Marts
- Population Builder
- Population Builder: Stratification
- Leading Wisely
- Leading Wisely: Population Health
- Community Care
- Excel-friendly Analysis Tools

Services within the Solution

- PHM Solution Optimization
- PHM Opportunity Analysis

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Use Cases

- An organization is participating in a commercial payer risk-based arrangement and recently received a monthly report from the payer that shows the organization has a PMPM that is trending higher than the established target. The VP of Population Health is concerned—and unsure how to use her data to learn about the organization’s PMPM drivers. Working with Health Catalyst SMEs, she and her team configure and use the Foundations technology to:
 - Establish data logic, models, and metrics appropriate to the organization’s commercial contracts and covered populations
 - Identify the drivers of the PMPM, including but not limited to top diagnoses and in and out-of-network utilization rates
 - Identify and stratify individual patients who are high utilizers—and then export these cohorts into their existing workflow tools
 - Determine which physician groups have a high concentration of patients with non-expected ED visits
 - Plan interventions to address these and other improvement opportunities and configure data dashboards to surveil KPIs related to managing the high PMPM trend
 - Monitor their trending performance in an executive dashboard

- An ACO leadership team is trying to identify performance trends that may affect their success in at-risk contracts. They need to understand whether they’re likely to hit their quality-reporting targets and where there are gaps. Further, they need to know how large those gaps are: how many patients do they need to impact to hit each quality reporting target? The team is able to use the Foundations technology to address each of these questions, helping them to identify gaps in care, drill down to the patient level for follow up, set priorities for improvement, and establish an ongoing monitoring process to determine intervention success.

- An organization has decided to enter into a Medicaid risk-based contract arrangement and needs to identify its high-utilizer populations. The organization’s population health management team uses the Foundation technology to learn that their high-utilizer population mainly consists of patients with ED visits who are diagnosed with Substance Abuse Disorder and/or Behavioral Health conditions. The team uses the Foundations technology to stratify this population into several group categories and develops a specific intervention for each group. The team then develops a Medicaid ACO executive dashboard that tracks key utilization metrics and intervention outcomes across all group categories within their population.

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