Now incorporates ACO MSSP Measures—Helps teams review population health data to identify opportunities for improvement in tracking, monitoring and meeting the needs of high-risk patients.

Community Care is aimed at primary care clinical program leaders, primary care providers and care coordinators working in ambulatory settings, quality improvement teams, and staff responsible for reports related to the organization’s status as an Accountable Care Organization (ACO). The focus is on providing data to help organizations review population health; compare their performance to national benchmarking standards for specific measures; identify opportunities for costs savings, and help practices track, monitor, and meet the needs of high-risk patients.

**Data Sources**

- EMR
- Patient Satisfaction
Key Measures

Multiple metrics have been identified and a full list can be found in the Technical Document; however, the key metrics are listed below. It should be further noted that the Qlikview reporting tool allows for further comparisons that may not be listed here.

- **Lab results with control indicators**: LDL and HbA1c blood test results and a field that indicates LDL over 100 will be out of control, and HbA1c levels over 8% are out of control.

- **Vitals with control indicators**: currently only systolic blood pressure and diastolic blood pressure results and an indicator of out of control if either are high (systolic over 139 or diastolic over 89).

- **Diabetes in control indicator**: patients are only in control if all 5 measures (D5) are in control. They need to have in control 1) LDL, 2) HbA1c, 3) blood pressure, 4) aspirin prescribed (if comorbidity of cardiovascular disease), or 5) documentation patient is a non-tobacco user.

- **Preventative in control indicator**: patients are in control if they fall within age buckets for preventative screenings and have received them (results not important). They need to have a screen for 1) cervical cancer (female), 2) mammograms (female), 3) colonoscopy over 50 years old, 4) Chlamydia test (female is sexually active), 5) influenza vaccination, 6) pneumococcal vaccination if 65 years old.

Background and Problem Summary

The healthcare industry is intensely focused on improving the quality of patient care while simultaneously lowering cost. It’s increasingly clear that a system built upon a foundation of strong preventive and primary care is critical to achieving these goals. Delivering high-quality, efficient, patient-centered care begins with a primary care system that can effectively manage the health of patient populations.

AHRQ reports that 5 percent of the population accounts for 50 percent of healthcare costs; this fact is a primary driver of the need to effectively manage the health of populations. Many of the drivers of overall cost are chronic conditions. Being able to easily identify patients with preventive or primary care gaps is the first step in improving care and outcomes. Yet currently, most organizations lack the ability to track and monitor needed primary and preventive care metrics. They also lack the actionable analytics that support outreach to specific patients for care follow up and help providers easily see what screening, monitoring, and therapies are needed for patients during primary care visits.
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 MI.
- A primary care provider and diabetes educator want to gauge the impact of several new initiatives aimed at improving diabetes self-management.
- An obstetrical provider wants to see how many of her patients have been screened for chlamydia.
- After a particularly brutal influenza season, an organization wants to review immunization rates and patterns to help them design a community health campaign for the following year.

Opportunity Insights

- Improved reporting on and compliance with best practice preventive and primary care measures (e.g., PQRS, etc.).
- Improved screening and primary care for specific populations of high-risk patients, especially those with diabetes, heart failure, hypertension, hypercholesterolemia, and other chronic conditions.
- Improved patient satisfaction related to the health system’s proactive outreach services.
- Increased capacity for care providers to identify care gaps for specific patients and take action during the current office visit.
Potential Improvements

Opportunity Identification:
- Identify gaps in preventive and primary care within your patient population.

Process Improvements:
- Support delivery of a list of patients with care gaps for generating outreach letters encouraging patients to schedule an appointment or connect with a care manager.
- Improve compliance with best practices for delivery of preventive and primary care during the current or future follow-up care.

Outcomes Improvement:
- Increase by XX% the percent of diabetes patients with HbA1c lower than 6.5%
- Improve by XX% the percent of patients age 50 or older whose care is compliant with colonoscopy screening guidelines.
- Increase percent of patients over 50 years of age who have received recommended pneumococcal and influenza vaccines.