CT HealthLink
Connecting for Better Care

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www.CTHealthLink.com

Analytics Dashboards

High Risk Patient

Dashboard identifies patients considered most at risk for poor health outcomes, high resource utilization and in need of care coordination. Identifying high risk patients can help meet the Clinical Practice Improvement (CPI) requirements under MIPS. For this analysis, high risk patients are defined as patients with three or more chronic conditions and five or more emergency department visits in a 12-month period.

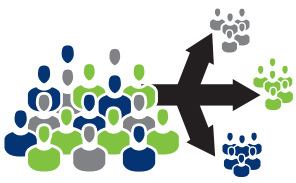
Quality Metrics

Dashboard displays analysis of preventive care procedures commonly required and approved for quality reporting programs for clinic practices. Individual measures are structured to meet NCQA, CMS, and HEDIS requirements. Current reported measures include screening for colorectal, cervical and breast cancers, osteoporosis, and pneumonia and influenza vaccines.

Readmissions

CMS has identified seven clinical conditions for which hospitals could receive a readmit penalty if a patient is readmitted at the same, or any other eligible facility, within 30 days of discharge for any reason. Readmission measures include acute myocardial infarction, chronic obstructive pulmonary disease, heart failure, elective hip or knee replacement, stroke, pneumonia, and coronary artery bypass graft.

Disease Registries



Display specific patient populations with certain high or at risk conditions, and sets the stage for physicians to take steps that mirror many of the MIPS CPI activities. The disease registry data provides information about the health status of communities and identifies opportunities for care coordination, referral to community resources, and evidence-based practices.

Population Health

Population Health presents opportunities for community resource coordination and planning for at risk members of a defined geographic region. Analysis is currently provided on 15 predetermined criteria selections such as hypertension, ischemic heart disease, pre-diabetes, diabetes, heart failure, and A1C poor control, to name a few.

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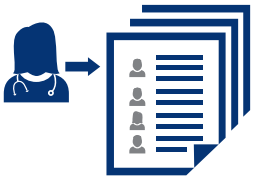
Behavioral Health

Behavioral Health presents an overview of specific metrics that address early detection, treatment and management of patients with behavioral health and medical conditions, including depression, suicide risk, diabetes, high blood pressure, and other related health conditions. Compliance for each measure is also available.

Utilization

Utilization dashboard presents recent patient activity for inpatient admissions, emergency department, and office visits. View selection includes filters for date ranges from 24 hours to 120 days and selection of a single or group of facilities. This dashboard displays all patients in the population with eligible service activity, un-restricted by age, disease condition, or level of utilization. Additional charts display office visit activity.

Patient Attribution



Patient Attribution provides a simple interface for management and assignment of patients based on provider and payer. The summary view displays patient name, visit activity, and most recent primary provider and payer. Patient level encounter detail is available. Views include a provider specific list and an administrative overview of all patients.

Controlled Substances

Controlled Substances dashboard presents patient activity where at least one prescription in the controlled substances category is prescribed and dispensed, as well as those that received an overlapping opioid prescription. Chart overviews include breakouts by facility and date range of prescription, overlapping prescriptions over 12 months, and top five opioid medications prescribed.

Polychronic Patients

Polychronic patients dashboard displays patients with three or more chronic clinical conditions with visits within the past 12 months. Patients may be more likely to consume health resources and may benefit from care coordination and periodic contact.