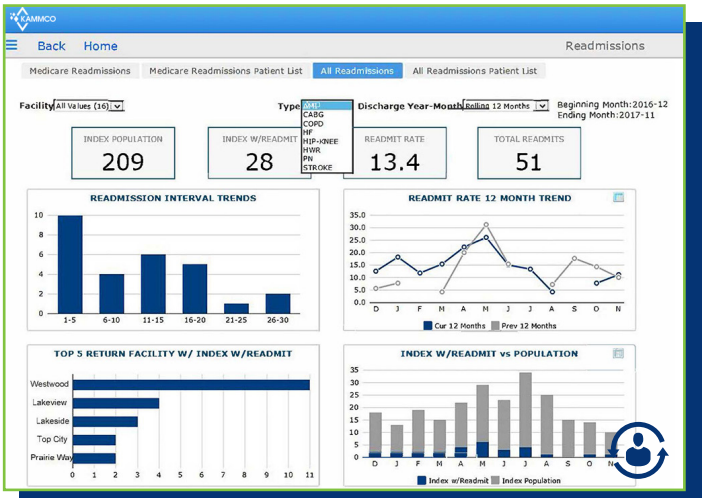
Using Clinical Data to Improve Care Coordination and Efficiency

Connecticut physicians can access powerful performance data through **CTHealthLink**, the physician-led health information network. Analytics tools of the past often failed to provide effective integration of all a patient's data. Today, organizations with a data analytics strategy built upon participation in a successful HIE will be well positioned to better manage care coordination, therefore lowering readmission rates.

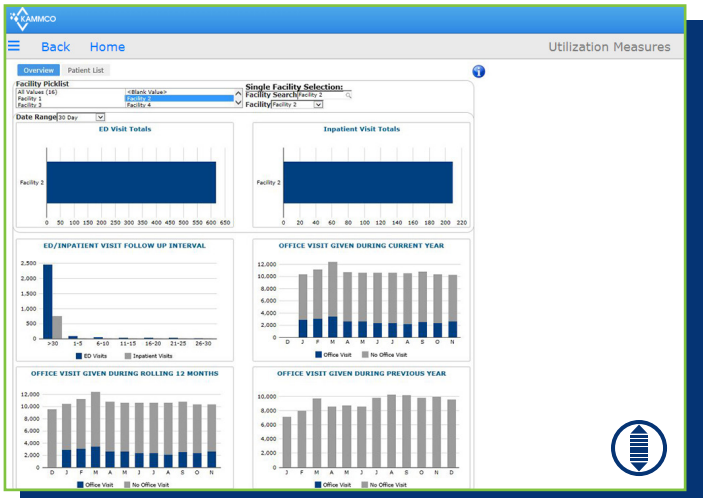
CTHealthLink analytics dashboards can ease the transition to QPP reporting by providing physicians access to patients' aggregated data from the HIE presented through meaningful analysis.

Dashboards available include: Quality Metrics, High Risk Patient, Readmissions, Disease Registries, Population Health, Utilization, Behavioral Health, Patient Attribution, Controlled Substances, and Polychronic Patients.



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.



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.

Call 203.641.7046 or 844.424.4368 today to set-up a demonstration. To learn more, visit www.CTHealthLink.com.