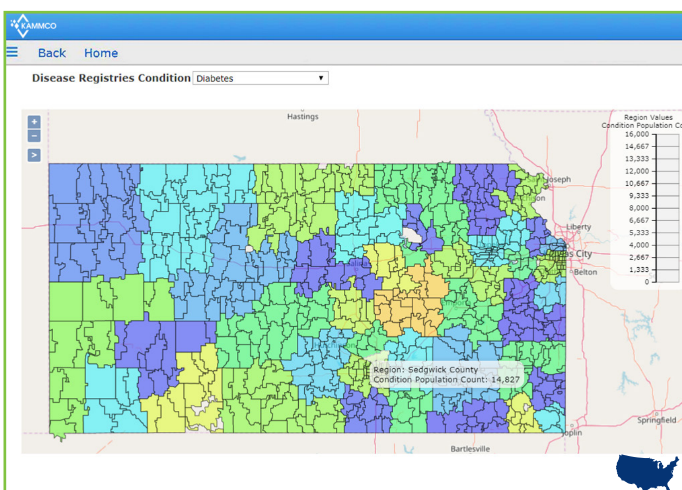
Using Clinical Data to Affect Population Health

Business intelligence and analytics such as those generated by **CTHealthLink** detect information patterns and present unseen alternatives. Analytics-driven acumen helps physicians identify and treat at-risk populations, proactively engage patients sooner, understand the performance of health interventions on health outcomes, and reduce costs.

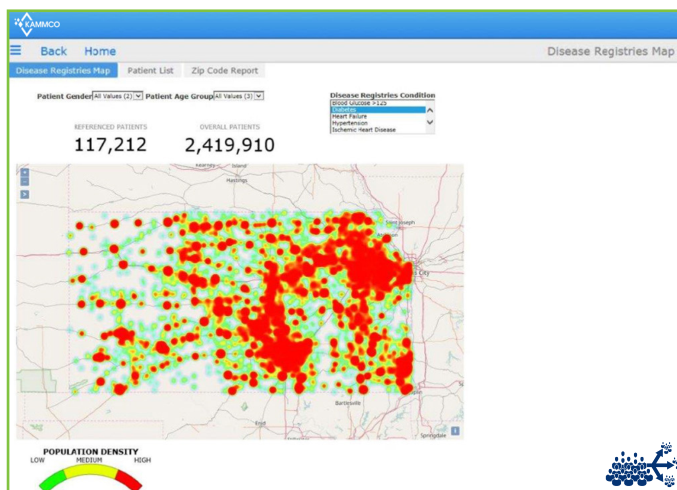
CTHealthLink analytics dashboards can ease the transition to QPP reporting by providing physicians access to patients' aggregated data from the HIE presented through meaningful analysis.

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



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.



Disease Registries

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.

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