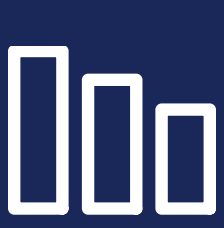
WHAT TO LOOK FOR IN A POPULATION HEALTH MANAGEMENT TOOL

CARE GAP ANALYSIS

Care gap analysis can be used to identify patients to address with preventative and critical care needs. It should also look for patients with a certain number of chronic conditions to enroll them for the Chronic Care Management program, or for patients who have had a certain amount of time elapse since their last appointment.

CLINICAL QUALITY MEASURE TRACKING



If CQMs are a practice focus, the provider wants to be able to check compliance with those measures and ensure patients are complying with enough measures to secure incentive payments for the practice.

CHRONIC CARE MANAGEMENT

The tool should highlight high-risk patients who may be eligible for CCM. Once enrolled it can pull up a monthly list for non-face-to-face care via phone or the patient portal, where a provider can walk patients through points based on their individual care plan.

PATIENT ENGAGEMENT

Instead of individual manual calls to each patient, the tool should be able to perform a mass outreach by sending an automated telephone call or text message to the designated patients reminding them to take and action or come in for an appointment.