Allscripts®

How can you drive better outcomes for your patients?

Pre-visit planning and post-visit monitoring support greater wellness across your patient population. Learn how with Allscripts® Care Partner.

Meet Beth and her care team.

As part of a strategic care campaign, Beth was identified as being overdue for a visit.

01 Targeted Analytics

Working with your organization to **identify clinical metrics** for improvement and actively engage high-risk patients.

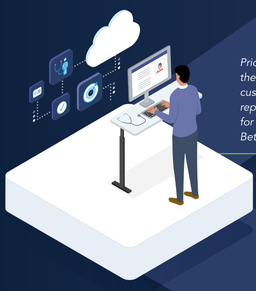
- Improve the health of your patient population
- Unlock new revenue streams

Meet Beth, a 67-year-old woman with uncontrolled diabetes who has not been seen in the last six months. Dr. Manning's scheduler understands Beth is diabetic and therefore needs an appointment ASAP. Beth is scheduled for the most appropriate time and visit type.

02 Consultation

A **Care Partner consultant** will proactively reach out to patients, leveraging optimized templates to schedule them in the most appropriate time slot.

- Optimize staff and scheduling efficiencies
- Improve patient satisfaction



Prior to Beth's appointment the practice will receive a customized pre-visit planning report that will help prepare for and effectively manage Beth's visit.

03 Pre-visit Planning

Using **Pre-visit Planning**, the patient's visit is prepared with targeted clinical gaps to close and diagnoses that should be assessed and reevaluated via documentation and ICD-10.

- Increase time provider spends with patient, and point-of-care efficiencies

Beth arrives for her visit with Dr. Manning, and he sees she is overdue for an A1C and is due for both a mammogram and diabetic retinal scan.

Dr. Manning pays close attention to his documentation, ensuring that the most specific and accurate ICD-10 and HCCs are addressed.

04 Point-of-Care Insights

Point-of-Care Insights can alert caregivers to any prioritized clinical care gaps that need to be addressed and document these in the EHR.

- Improve quality of care

Sarah, Dr. Manning's nurse, completes Beth's A1C results and prepares both her referral for a mammogram and a diabetic retinal exam.

05 Patient-centric Care

A **Care Partner consultant** identifies like-minded specialists that deliver patient care in a cost-effective and timely manner—establishing best practices on referral workflows and ensuring sustainable processes and visibility to problem areas moving forward.

- Improve referral management

As Dr. Manning wraps up with Beth, he instructs Sarah to schedule a follow-up A1C and her Annual Wellness Visit (AWV).

06 Addressing Clinical Gaps

Working with your organization, a **Care Partner consultant** will put together a strategic care plan and schedule all necessary follow-up appointments—proactively addressing potential clinical gaps and creating ongoing revenue streams for the organization.

- Close quality gaps
- Increase revenue production

After Beth's visit, the organization billing office files the claim with Beth's insurance and Dr. Manning is paid. The nursing staff ensures follow up on mammogram and retinal exam are received and appropriately documented within the chart and continue patient monitoring, education and outreach.

07 Care Monitoring and Follow Up

As part of a care campaign strategy, the **Care Partner consultant** will identify non-compliant patient referrals among other improvement activities, including continuous monitoring and recommendations for operational and/or clinical workflow efficiencies.

- Improve overall patient outcomes

To learn more about Allscripts Care Partner, visit allscripts.com