SONIC HEALTHCARE USA

MENU

About Us Population Health Management

Leverage Data to Proactively Manage and Engage Your Patients

Use Routine Lab work for Enhanced Population Health

In collaboration with your local Sonic Healthcare USA (SHUSA) laboratory, there is a new Population Health Informatics Program that will give you a critical edge in predictive diagnostics. Along with their outstanding community-based laboratory medicine services, your local SHUSA laboratory brings to the table the advanced, proprietary medical informatics engine called, iMorpheus®. The iMorpheus solution provides real-time clinical decision support and advanced healthcare informatics capabilities utilizing an agile pattern recognition software guided by Sonic's world-class medical expertise. iMorpheus supports evidence-based practice, care coordination, and accountable care delivery for Sonic Healthcare's lab partners, clients, and patients.

iMorpheus provides:

- EMR data integration to help you with PQRS/HEDIS/GPRO reporting
- Integrated chronic disease registry to alert you to probable under-diagnosis
- Chronic disease care gap identification with alerts for under-management
- Integrated clinical and financial risk stratification to help you prioritize patient load
- Integrated PPHC care management and automated patient engagement to help you reach your patients
- Laboratory formulary to provide algorithm-based laboratory work-ups

Integrated Chronic Disease Registry

Under-diagnosis of chronic conditions, such as diabetes and chronic kidney disease (CKD), continues to be a challenge in primary care settings, often resulting in delayed management, disease progression and costly complications downstream. Under-diagnoses also negatively impacts your incentive payments in programs where diagnosis-based financial risk-adjustments are
used (e.g., MSSP, Commercial Shared Savings.)

These registries will help identify those patients who:

- may be under-diagnosed so you can follow-up accordingly
- may have insufficient or omitted coding, allowing you to code appropriately for maximized shared savings distributions
- may be candidates for Chronic Care Management (CCM) programs and associated reimbursements

- may be mis-coded to indicate non-existent chronic diseases which can negatively impact your GPRO/CQM's/PQRS

Chronic Disease Care Gap Identification

iMorpheus will identify potential care gaps for your patients, including: GPRO measures, routine lab monitoring for chronic diseases (HbA1c, LDL, Microalbumin for diabetes), and standardized therapy like ACEI/ARB for CKD, beta blockers for heart failure or cholesterol-lowering agents. These automated alerts will help you continuously monitor and manage your patients in their homes and allow you to structure regular in-office exams in accordance with the current standards of practice.

Care Management and Automated Patient Engagement

Under the traditional practice model, care occurs only when a patient arrives for an appointment. Many practices lack the infrastructure to continuously monitor patient progress in their home environment and to reach out to schedule needed in-office appointments.

iMorpheus solves this challenge by providing integrated electronic and mobile patient engagement tools like automated calls, texts and emails. These tools are customized for your practice to help you automatically connect with your patients to deploy care plans and schedule office visits. The system will also coordinate with current care management initiatives to help your practice bring even more effective care to your patients.

Ready to Learn More

Click here to connect with the iMorpheus team.

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CONTACT

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