Support your mission with provider-led population health

Empower your teams to more efficiently and consistently improve the health of populations.

Community Health Centers (CHCs) are dedicated to the mission of providing high-quality, patient-centered care at a low cost to the most vulnerable and underserved patients in our communities. CHCs are truly the pioneers of value-based care, and Virence Health is here to support your mission. To optimize operations, we've combined the tools for population health, care delivery, financial management, patient engagement, analytics, and connectivity into a single solution specifically designed for CHCs.

The ambulatory population health capabilities within our CHC solution help centers more efficiently prioritize patients for intervention and more consistently deliver care that follows current evidence-based guidelines. Role-based care plan workflows informed by the latest patient information help unify care teams – improving consistency and quality of care among patients with similar health issues.

The flexible CHC population health solution enables providers to deliver informed care more efficiently than when using an EMR alone by streamlining what today are often disconnected systems and manual processes. Additional pre-defined programs designed to help deliver success in chronic care management and transitional care management are available to help maximize value-based payment capture and support your mission.

Population Health Benefits

Prioritize patients for intervention

Easily visualize patients with gaps in care and group them with others who share similar health issues and prioritize groups for intervention.

Efficiently manage populations

Develop condition-specific care plans, apply them to the appropriate population, and efficiently manage activities for the entire group.

Coordinate across the care team

Role-based workflows enable more efficient execution of patient specific care plans and easy collaboration with other members of the care team.

Deliver thorough, consistent care

Point-of-care decision support, incorporating data and evidence-based guidelines, helps you consistently close gaps in care during the visit.

Capture value-based payments

Optional pre-defined programs help deliver success in chronic care management and transitional care management.

Enhance Care Quality

Identify patients most in need of intervention – Stratify patient populations by risk, clinical and financial characteristics and optimize care team activity.

Reinforce consistency of care – Reduce care variations through evidence-based guidelines for patients with similar conditions across care teams.

Use evidence-based care as the standard – Reference the latest guidelines for the treatment of specific conditions and use these standards to build care plans.

Drive improvement with insights – Track quality metric performance and then drill down by site, provider, or patient to identify actionable insights.

Increase Provider Efficiency

Optimize team care activity – Ensure that care team members are assigned tasks most suited to their skills so everyone practices at the top of their license.

Extend provider reach – Free physicians from task delegation to focus more on active care.

Easily access population health capabilities – Reduce clicks and streamline the clinical workflow with capabilities embedded directly within the native EHR.

Accelerate the process for closing gaps – Notify providers of care gaps automatically and streamline communication with patients experiencing gaps.

Strengthen Financial Performance

Deliver needed services – More easily identify and close gaps in care to better serve your patients and support financials.

Optimize contribution of staff – Improve staff return on investment by enabling care teams to practice at the top of their license.

Supplement payment for care delivered – Leverage optional components to earn payment for management of chronic illnesses or transitions in care settings.

Accelerate Your Transition to Value-Based Care

Better manage chronic conditions – With evidence-based care plans, you can drive improved outcomes for the most prevalent diseases and conditions.

Prioritize care delivery – Patients who need the most, get the most.

More easily achieve incentives – Set quality goals consistent with incentive payments, visualize progress to goals, and easily report on key metrics that are important to CHCs such as UDS, HEDIS, and ACO.

Join us for the journey

Our new IT solution for CHCs is just the beginning of our commitment to you. It is the first step in an evolution into a comprehensive, fully integrated, interoperable and intelligent cloud-based software solution that will combine decades of healthcare expertise with cutting-edge capabilities and a modern user experience. One that puts patients where they belong – at the center of care. One that only Virence Health can deliver.

86% of patients
at highest risk saw improvements in LDL goal attainment[1]

Added ~400K
in incremental annual revenue[2]

Engaged patients
through health literate information and tools[3]

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1. "A Randomized Controlled Trial of Team-Based Care: Impact of Physician-Pharmacist Collaboration on Uncontrolled Hypertension", by Jacquelyn S. Hunt, Pharm D MS, Joseph Siemienczuk, MD, Ginger Pape, Pharm D, Yelena Rozenfeld, MPH, John MacKay, Pharm D, Benjamin H. LeBlanc, MD MBI, and Daniel Touchette, Pharm D MA, Journal of General Internal Medicine, December 2008
2. **Source:** Center for Primary Care, chronic care management study
3. **Source:** Central City Concern diabetes management study

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