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Caradigm® Readmissions Management

Caradigm's products are designed to help healthcare organizations connect systems and aggregate data across the community, gain insight through near real-time analytics, accelerate caregiver access to data, maintain regulatory compliance, and rapidly implement new applications to enhance the understanding and management of risk that lead to better clinical outcomes and financial results across the continuum of care. With a robust platform and application ecosystem, Caradigm enables the cross-boundary collaboration necessary to unleash innovation, unlock insight and transform healthcare.

Unleashing Innovation

Caradigm Readmissions Management uses a highly effective algorithm, developed in conjunction with Microsoft Research, to help health systems identify and stratify patients at highest risk for readmission.

Unlike other readmissions prediction systems, Caradigm employs machine learning to train the algorithm to adjust its calculations based on each customer organization's data. Because it is built atop the Caradigm Intelligence Platform (CIP), Readmissions Management benefits from a richer data asset than other applications. CIP aggregates and makes available, in a consistent and secure fashion, the clinical, financial and operational data that healthcare organizations can use to reduce unnecessary readmissions.

Unlocking Insight

Caradigm Readmissions Management allows healthcare organizations to identify, stratify, analyze and manage high-readmission-risk patients. This application provides intuitive and insightful views of key data for case managers, physicians, charge nurses, nurses and executive supporters.

In addition to its predictive algorithm and machine learning, Readmissions Management offers functionality that targets key aspects of patient care.

- Screening tools to facilitate identification of additional readmission risk factors.

- Ongoing surveillance of high-risk patients in the hospital to enable early identification of emerging readmission risk factors and augment pre-discharge care coordination.

- With Caradigm Care Management, provides standardized patient management and discharge planning to enhance care documentation via structured document templates for assessments and discharge plans.

- Post-discharge task management to support management of key risk factors affecting readmission.

- Comprehensive information to allow organizations to measure the results of managing patients at high risk for readmission.

Challenges

According to a study in The New England Journal of Medicine, one in five elderly patients is readmitted to the hospital within 30 days after leaving. This amounts to 2.3 million re-hospitalizations per year, and $17 billion in Medicare costs. The study claims that about 40% of these re-hospitalizations are avoidable.

In October 2012, the Centers for Medicare and Medicaid Services (CMS) began penalizing hospitals for readmissions that fall above the national average for heart failure, acute myocardial infarction and pneumonia. Hospitals with a higher-than-average readmission rate will incur a penalty of up to 1% across all Medicare payments, with the penalty increasing to as much as 3% by 2015.

[1]Rehospitalizations among Patients in the Medicare Fee-for-Service Program. Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H. N Engl J Med 2009; 360:1418-1428 April 2, 2009

Caradigm Readmissions Management

Transforming Healthcare

With the support of IT solutions, healthcare organizations can achieve their clinical outcomes and financial results. Comprehensive views of patient data and required patient management tasks contribute to informed decision-making and enable clinicians to provide proactive intervention.

Caradigm Readmissions Management:

- Provides content alignment with payment adjustment models for readmissions reduction programs around heart attack, heart failure, pneumonia, COPD, and hip/knee arthroplasty
- Helps organizations understand financial impact due to hospital readmissions, accounting for non-penalty readmissions
- Facilitates proactive identification of high-risk patients
- Helps clinicians maximize the opportunity to reduce readmission risk during the patient's hospitalization
- Enhances post-discharge management to enable healthcare organizations to provide proactive intervention and improve patient behavior to decrease readmissions
- Continuously measures success with populations at risk for readmission

In addition to Readmissions Management, Caradigm offers other applications that help healthcare organizations address the underlying causes of preventable readmissions.

- Inpatient surveillance applications for catheter-associated urinary tract infection, central line-associated bloodstream infection, sepsis, etc. will allow clinicians to address healthcare-associated infections that contribute to 27% of preventable readmissions.
- Chronic disease surveillance applications will help organizations manage at-risk patient populations. Six chronic conditions—heart failure, chronic obstructive pulmonary disease, acute myocardial infarction, depression, asthma and diabetes—alone account for 22% of readmissions.
- Connection to Get Real Health's InstantPHR™ (IPHR) enhances patient engagement and gives organizations the means to achieve better personalized care management and increased capacity to influence patient behavior during the high-risk readmission period.

All applications are built on the Caradigm Intelligence Platform which enables them to reuse and share data across the set of applications.

Our portfolio of solutions provides insights healthcare enterprises need to better manage clinical outcomes and financial performance now – and in the future.

Together, we can transform healthcare.

ABOUT CARADIGM

Caradigm is a healthcare analytics and population health company dedicated to helping organizations improve care, reduce costs and manage risk through the strategic, timely and compliant use of data generated across the healthcare continuum.

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