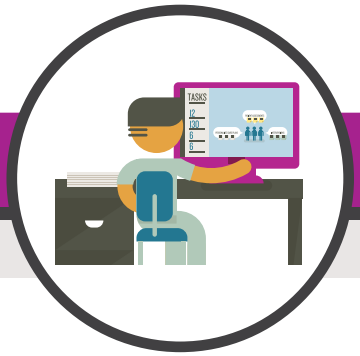
caradigm

CARADIGM® CARE MANAGEMENT

DATA SHEET



Overview

As healthcare organizations seek to succeed with population health, scaling care management for high-risk and rising-risk patients is often a foundational strategy. Caradigm® Care Management is an enterprise solution designed to improve coordination of a multidisciplinary team across the continuum to help healthcare organizations manage large patient populations. The cornerstone of Caradigm's population health application suite, Caradigm Care Management integrates evidence-based clinical guidelines into patient-centric care plans to deliver improved patient outcomes and care efficiency for high-risk patient populations.

Built for care coordinators and care managers, the application provides tiered, extensible assessments, customizable workflows and embedded task logic that helps clinicians identify all factors that may impact the patient's ability to improve their health.

Dynamic, data-driven plans of care are generated based on assessment data and the patient's longitudinal care record. Care plans are further personalized to include patient-driven personal goals tied to healthcare goals/outcomes to maximize each patient's engagement in the management of their own health. Automated, event-based tasking—enabled by data ingestion from external sources—assists care managers in tracking each patient's progress to goals and identifying and managing any barriers to following their personal care plan.

Key Features

- Comprehensive, extensible assessments
- Personalized, data-driven and dynamic plans of care
- Evidence-based workflows
- Content Builder tool to develop custom assessments
- User-defined, prioritized care management dashboard
- Role-based tasking to enable top-of-license work
- Streamlined medication review
- Automated, event-based tasking
- Tracking and reporting of time spent per month
- Flag and follow bundled-payment candidates

Key Benefits

- Improve coordination of care among disparate providers
- View comprehensive, cross-community patient data
- Enable clinicians across the healthcare community to provide proactive intervention
- Increase patient engagement
- Enhance clinical and financial outcomes
- Help organizations more predictably manage cost and risk
- Measure performance of teams and individuals
- Support Medicare CCM program
- Support bundled-payment programs

[1] Erdem E. Prevalence of Chronic Conditions Among Medicare Part A Beneficiaries in 2008 and 2010: Are Medicare Beneficiaries Getting Sicker? Prev Chronic Dis 2014;11:130118. DOI: http://dx.doi.org/10.5888/pcd11.130118

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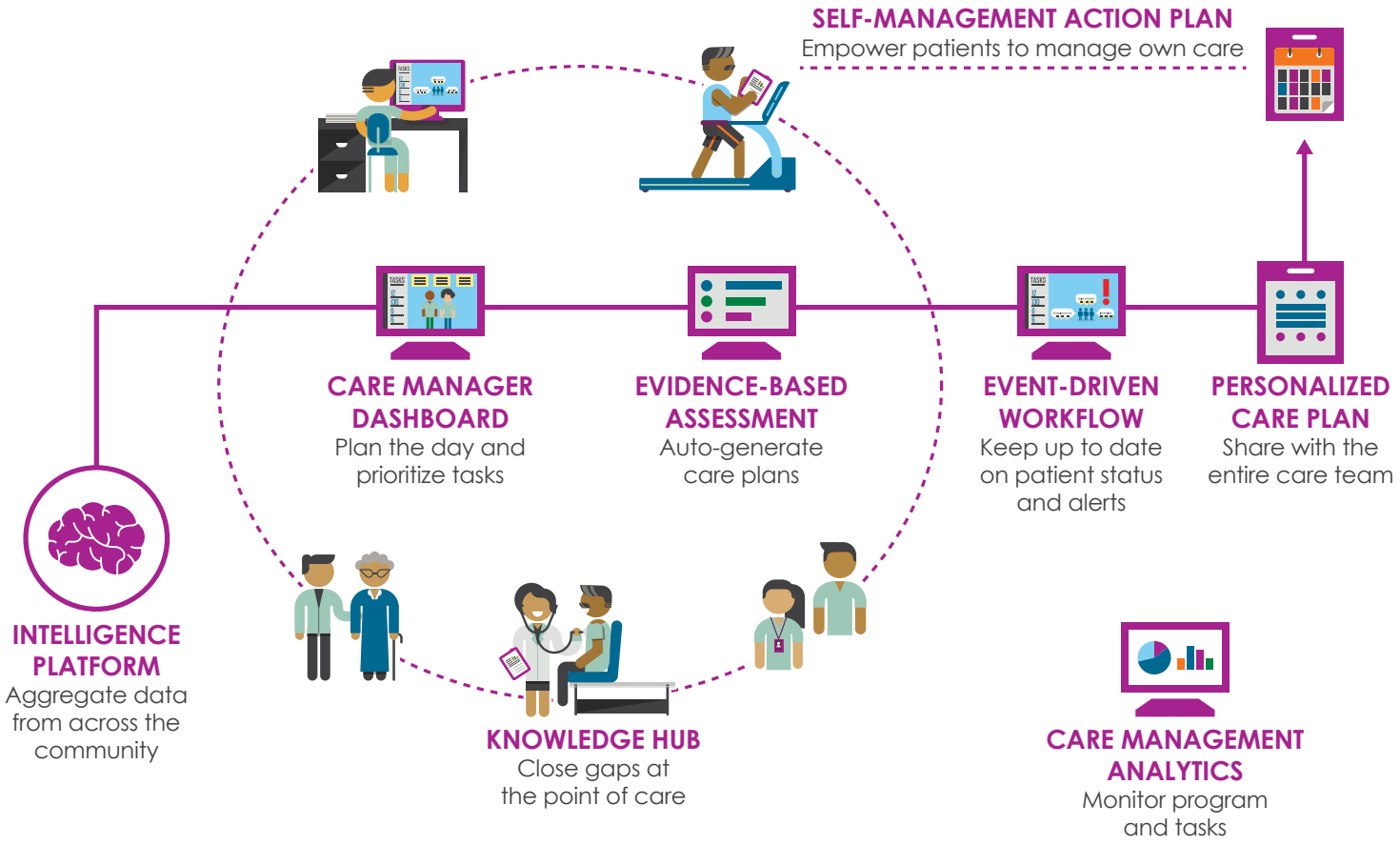
How it Works

Caradigm Care Management delivers the standardization and efficiencies to scale for large populations.



Summary

Caradigm Care Management helps streamline the management of patient populations and enables more efficient use of evidence-based medicine across the community. The application marries care pathways with an aggregated, cross-community record that presents the most relevant information from clinical and administrative records.

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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.