Overview

To maintain focus on current operations while positioning themselves for the opportunities in the value-based reimbursement market, many hospitals and physicians have turned to clinically integrated networks (CINs) as a viable option. CINs form to address four aims—improve the quality of care, reduce cost and waste to maintain margin, sustain independence for physicians, and position providers to take on population health management (PHM) initiatives.

Growing in number since 1996, when the Federal Trade Commission provided guidance on antitrust enforcement policies, there are an estimated 500 CINs today. In addition, we have seen CINs joining together, forming so-called “super CINs” to address a defined population across a state or region.

Needs and Challenges

Having worked with a number of CINs, Caradigm understands the specific needs and challenges they face.

• While existing IT solutions like electronic medical records (EMRs) and health information exchanges (HIEs) have helped CINs improve quality and efficiency, they have fallen short in enabling CINs to effectively manage utilization and the health of populations.

• Providers in a CIN use different EMRs. This can make it difficult to aggregate and share the patient information that is necessary to coordinate and manage care across a community.

• In order to land employer contracts (and address laws that prohibit joint contract negotiations), CINs must select physicians that demonstrate higher quality and greater efficiency.

• To achieve financial targets, CINs need to identify patients who will incur high costs, coordinate their care, and manage utilization or services within the network.

IT Keys to Success

To achieve their goals, CINs require new types of information technology solutions that allow them to understand and manage clinical and financial risk for optimal outcomes.

• Data Control: A platform that can aggregate and share longitudinal patient records across multiple EMRs provides the single source for clinicians to deliver high-quality care

• Risk Stratification and Care Coordination: Predictive models can identify which individuals are most likely to provide the greatest return on intervention; automated care plans, task lists and interventions—based on evidence-based guidelines—enables the efficiencies for growth.

• Patient Utilization and Provider Performance: Analytics applications with drill-down capability, can identify high utilizers and higher-cost providers, track network-steerage patterns and uncover opportunities for improvement.

Caradigm offers an enterprise portfolio of solutions to support these aims.
Caradigm is a population health company dedicated to improving patient care, advancing the health of populations and reducing healthcare costs. Its enterprise software portfolio helps organizations deliver effective population health management, including data control; healthcare analytics; and care coordination and engagement.

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<tr>
<th>CARADIGM SOLUTION</th>
<th>DESCRIPTION</th>
<th>VALUE</th>
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| Risk Stratification           | Identify at-risk patients that would benefit from care management or patient outreach. | Use patient lists to initiate interventions for high-risk patients.  
• Clinical data from multiple sources  
• Filters for chronic comorbidity count & clinical factors  
• Out-of-the-box standard & custom registries  
• Streamlined referral to Caradigm Care Management |
| Care Management               | Facilitate team-based coordinated care for complex, high-risk patients by sharing data across care settings. | Coordinate team-based care for high-risk patients by sharing information.  
• Evidence-based assessments and automated care-plan generation  
• Personalized plans of care to increase patient engagement  
• Real-time, role-based actionable alerts to drive best practices  
• Analytics to help identify and measure operational performance |
| Cohort Designer               | Configure multi-patient and single-patient views and define simple charts and reports. | Define and manage patient registries and populations.  
• Real-time surveillance  
• Drill-down into patient-level views  
• Trending to help address outliers  
• Campaign and program enrollment |
| Quality Improvement           | Identify, monitor and address quality compliance to drive volume and performance required for incentive payments. | Address quality compliance to drive volume and achieve targeted results.  
• Unified view of quality performance across the enterprise  
• Benchmarking for ACO, HCAHPS, HEDIS, PQRS, NQF and customer-defined measures  
• Root cause analysis of patient compliance and provider performance  
• Assignment of target populations to campaigns and programs |
| Patient Outreach              | Reach patients outside of the care setting to trigger health related behavior change. | Employ a scalable, cost-effective engagement tool for patient management needs.  
• Onboarding  
• Assessments  
• Readmissions reduction  
• Reminders  
• Condition monitoring  
• Custom programs |
| Knowledge Hub                 | Alert clinicians, within EHR workflows, to support better-informed decisions. | Communicate with physicians.  
• Access to a community-wide longitudinal patient record  
• Dynamic patient context for increased safety and reduced risk of errors  
• Configurable scorecard for clinically relevant metrics |
| Utilization and Financial Analytics | Understand the utilization health of the organization to uncover financial improvement opportunities. | Identify opportunities for improvement by understanding utilization trends.  
• Aggregation of data to reveal the operational health of the enterprise  
• Reports focused on the top indicators and drivers of utilization  
• Analytic filters for comparison of regions, facilities or providers  
• Drill-down to individual providers or patients for targeted actions |

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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