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cureatr Patient Care Score

Cureatr Patient Care Score Fact Sheet

Thanks for taking the time to learn more about Cureatr's Patient Care Score quiz!

No matter what you got on the quiz, there is always room for improvement. This Fact Sheet will give you more information about which answers would have given you the best grade and why!

1 Who performs most of your admission and discharge medication reconciliation?

- Physicians
- Nurses
- **Pharmacists** ***(Correct Answer)***
- Medical Assistants

Why?

An effective process for medication reconciliation reduces medication errors and supports safe medication use. Pharmacists are uniquely qualified to lead interdisciplinary efforts to establish and maintain an effective medication reconciliation process in hospitals and across health systems and should lead or assume key roles in the essential components of medication reconciliation. Because of their crucial role, pharmacists share accountability with other hospital and health-system leaders for the ongoing success of medication reconciliation processes across the continuum of care.

2 On which patients do you focus your medication non-adherence interventions?

- Patients who are on Part D triple weighted therapeutic categories (diabetes, hyperlipidemia and hypertension)
- **Patients on any critical maintenance medication** ***(Correct Answer)***
- We don't perform interventions for medication non-adherence

Why?

Studies have consistently shown **that 20 to 30 percent of medication prescriptions are never filled, and that approximately 50 percent of medications for chronic disease are not taken as prescribed.** People who do take prescription medications—whether it's for a simple infection or a life-threatening condition—typically take only about half the prescribed doses.

It is estimated that approximately 26% of preventable readmissions are associated with maintenance medication non-adherence. This lack of adherence is estimated to cause approximately 125,000 deaths and at least 10 percent of hospitalizations, and to cost the American health care system between $100 billion and $289 billion a year.

3 How often do your care managers routinely check in with all high-risk patients within two days of discharge?

- **Always** ***(Correct Answer)***
- Sometimes
- Rarely

Why?

Many studies have shown that preventable readmissions decline if:

- The patient fully understands the condition that led to hospital admission
- The patient understands newly prescribed medications—what they are for and how to take them
- The patient is aware of the dates and times of follow-up appointments—with both the primary care provider (PCP) and any new specialists
- Options for transportation to and from the appointment have been explored
- The patient is knowledgeable of signs and symptoms for which they should call their PCP or return to the ER

4 Which of the following actions do your emergency department case managers perform?

- **Identify patients that can be safely managed without admitting them to hospital** ***(Correct Answer)***
- **Help patients manage their condition as outpatients** ***(Correct Answer)***
- **Identify ED overutilizers and help develop plans and services to redirect them to other care settings** ***(Correct Answer)***
- None

Why?

Many EDs use their case managers to help determine whether a patient should be hospitalized as a full admission or as observation status because so much money is at stake for the hospital in getting this decision right.

ED case managers can also prevent admissions by providing patients with the resources they need to manage their condition as outpatients. It could be as simple as ensuring that DVT patients can obtain medication from the pharmacy (avoiding an observation stay while treatment is arranged). Likewise, ED case managers can prevent unnecessary hospitalizations in a variety of settings, including getting patients directly into a hospice bed or an assisted living facility from the ED. More commonly, it's arranging for home physical or occupational therapy, home nursing, a nurse aide to assist the patient with activities of daily living, or even providing a hospital bed for home.

ED case managers are also often utilized to address ED overutilizers. Under value-based payment models, providing the appropriate type of care in the appropriate setting becomes increasingly important. Many patients who are high users of ED services do not need this high level of care and as a result, hospitals must try to redirect these patients to other care settings. ED case management programs can put a plan in place that will do just that.

5 Real-time population programs include all but one of the following:

- Timely access to ADT-derived utilization including rates of readmission, length of stay, ER utilization and temporal trends by disease rate
- The ability to query and analyze indicators by enterprise, facility, and care manager
- **Delays associated with medical claims lag** ***(Correct Answer)***
- The ability to meet the needs of population health managers to rapidly identify targets for intervention

Why?

There is a pressing need in population health to access timely data. Current systems that depend primarily on administrative data sets are subject to claims lag of at least 3-4 months. In patients with chronic disease, this delay often results in missed opportunities to address cohorts of patients that may pose the greatest risk of preventable acute events such as readmissions and ER visits. In addition, a dashboard approach enables the ability to follow all patients, not just high risk, thus enabling early identification of patients transitioning into higher risk classes.

From a performance management perspective, a real time population health dashboard provides a vehicle of leadership to quickly pinpoint facilities that are utilizing best practices and performing optimally and those that would benefit by intervention and remediation.

Likewise, data from such a dashboard can be deployed to support a network management and narrow network strategy.

6 How often do you conduct discharge readiness interviews with patients?

- **For every discharge** ***(Correct Answer)***
- For the large majority of discharges
- For discharges where we perceive the patient may not feel prepared to be discharged
- We don't routinely conduct discharge readiness interviews.

Why?

Readmission causality varies extensively. Talking to patients directly and understanding patient readiness from the patient perspective is very important in readmission prevention. Research has shown that patients were more likely to think that their readmission was preventable if they felt unready for discharge during their initial hospitalization. A patient-centered discharge checklist helps patients identify questions they might have after discharge. Creating a discharge checklist also helps patients to put themselves in the position of being at home and working through scenarios they may face so they will know how to deal with them. For example, if you have pain, who should you call? What should you do if you run out of medication?

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