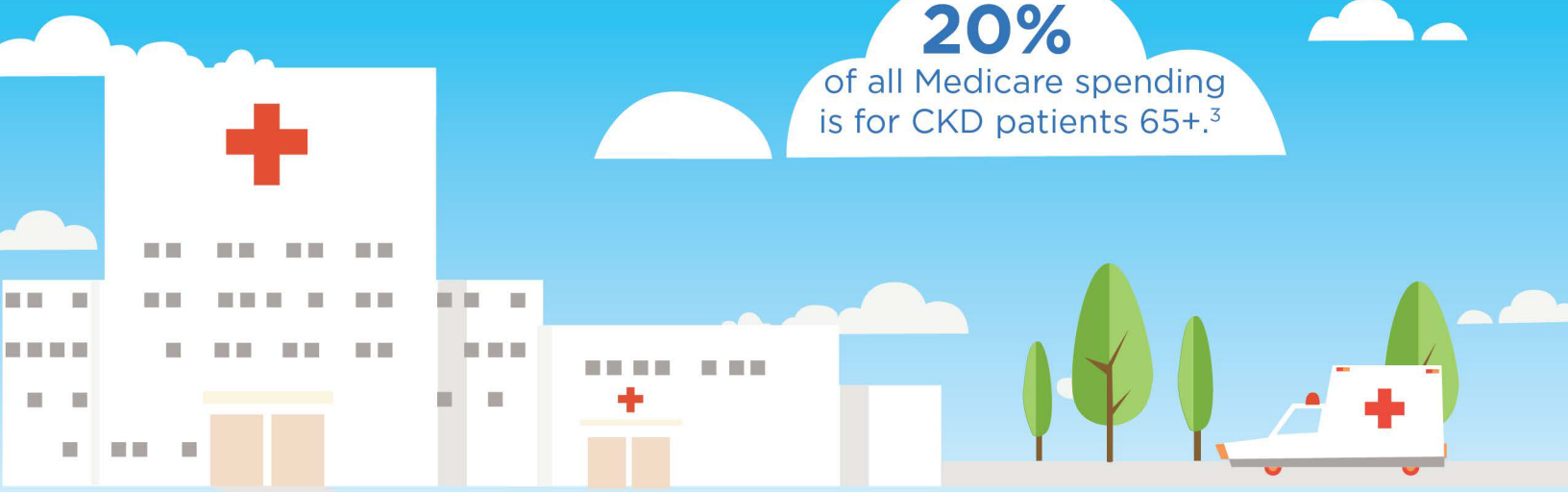
Actionable Care Coordination Impacts Chronic Kidney Disease Communities

31.6 million
Americans have CKD and ESRD.
That's 1 in 10![1]

14.2 million
experience unplanned hospitalizations.[2]

20%
of all Medicare spending is for CKD patients 65+.[3]

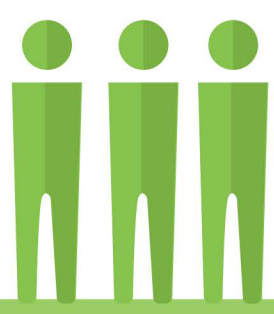


Know If Your Patients Recieve Care After Discharge
Take Action To Prevent A Re-admit

Notification of hospital discharges creates an active workflow for physician follow ups and re-activation to dialysis.

1 in 4
CKD patients are re-hospitalized

30
days after discharge[4]



✕ Readmitted
Care Team not notified or delayed in awareness of missed dialysis treatments.

Care team not notified of patient discharge– delay in scheduling physician follow up and dialysis treatment.

Medications and fluid levels not adjusted post discharge.

✓ Readmission Prevented
Care team is notified of missed dialysis treatments and reschedules appointment.

Doctors schedule follow ups for referrals and medication.

Doctors and coordinated care teams reduce readmission by **3.5%**[5]

The best way to prevent patient readmission is having a coordinated care team that knows where and when patients are receiving care or missing critical wellness targets.

Cureatr sends providers real time alerts during a patient's health event. Cureatr is part of the team that prevents future, unnecessary readmissions.

cureatr
comprehensive medication management

March is #NationalKidneyMonth

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[1] American Kidney Fund [2] CMS & USRDS: http://www.usrds.org/2015/view/v1_06.aspx [3] CMS & USRDS: http://www.usrds.org/2015/view/v1_06.aspx

[4] Elixhauser A (AHRQ), Steiner C (AHRQ). Readmissions to U.S. Hospitals by Diagnosis, 2010. HCUP Statistical Brief #153. April 2013.

[5] Wish, Jay B. "The Role of 30-Day Readmission as a Measure of Quality." Clinical Journal of the American Society of Nephrology: CJASN 9.3 (2014): 440–442. PMC. Web. 24 Feb. 2016.