The Core Elements of Value in Healthcare 1st edition Bindra Test Bank

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1. ch12-001
Between public and private payers and regular US households, the United States spent _____ on healthcare annually (as estimated in 2015).

a. about $9 trillion
b. more than $5 trillion
c. about $1.5 trillion
*d. more than $3 trillion

2. ch12-002
According to estimates, value-focused initiatives to eliminate waste related to overtreatment, failures in care coordination, failures in processes, administrative complexity, pricing failure, and fraud and abuse can achieve savings of _____ of total healthcare spending.

a. 8 percent
b. 40 percent
c. 5 percent
*d. more than 20 percent

3. ch12-003
During World War II, when wage increases were frozen, employers had to look for other ways to attract top talent; subsidizing employees' healthcare costs presented one such opportunity.

*a. True
b. False

4. ch12-004
Throughout the country's history, physicians in the United States have practiced under strict regulation and with a consistently high level of accountability to the lay public.

a. True
*b. False

5. ch12-005
The key sources of funding for US healthcare are

households, private business, and governments (federal, state, and local).

*a. True
b. False

6. ch12-006
In what year did Congress pass legislation to introduce Medicare for the elderly and Medicaid for the poor?

a. 1971
*b. 1965
c. 1945
d. 1953

7. ch12-007
The historical evolution of healthcare delivery in the United States led to a fee-for-service system with elaborate power dynamics between doctors, hospitals, insurance companies, and third-party payers.

*a. True
b. False

8. ch12-008
The United States spends nearly 20 percent of its GDP on healthcare, but other industrialized countries spend more.

a. True
*b. False

9. ch12-009
Medicaid, established in 1965 through Title XVIII of the Social Security Act, is a health insurance program primarily geared toward people 65 years of age or older.

a. True
*b. False

10. ch12-010
Diagnosis-related groups (DRG) classify patients into categories based on their diagnoses. DRGs are used as the

basis for reimbursement under Medicare's prospective payment system.

*a. True
b. False

11. ch12-011
The managed care version of Medicare is called _____.

a. Medicare Part B
b. Medicare Part C
c. Medicare Part D
d. Medicare Advantage (MA)
e. Both a and d are correct.
*f. Both b and d are correct.

12. ch12-012
Dual eligible beneficiaries are those beneficiaries who are eligible for both _____.

a. Medicare Part A and Medicare Part D.
*b. Medicare and Medicaid
c. I-SNPs and C-SNPs
d. Medicare Part B and Medicare Part D

13. ch12-013
Medicaid policy is set at the _____ level, but the program is administered by the _____.

a. state; federal government
b. local; states
c. local; federal government
*d. federal; states

14. ch12-014
Traditionally, Medicaid has functioned under a/an _____ model

a. value-based
b. HMO
*c. fee-for-service
d. managed care

15. ch12-015
Sections 1915(b) and 1115 of the Social Security Act provide waiver authority to states. These waivers provide the states with greater flexibility to establish their own managed care programs in Medicaid.

*a. True
b. False

16. ch12-016
Managed long-term services and supports (MLTSS) are long-term care services delivered through capitated Medicaid managed care programs, and they have helped reduce nursing home expenses.

*a. True
b. False

17. ch12-017
Managed long-term services and supports (MLTSS) programs have been implemented in nearly every state, with consistently positive results.

a. True
*b. False

18. ch12-018
The Medicare–Medicaid Coordination Office, established under the Affordable Care Act, collaborates with the Center for Medicare & Medicaid Innovation to develop new ways to coordinate and improve the care provided to the dual eligible population.

*a. True
b. False

1. ch02-001
The _____ refers to the full range of settings and stakeholders involved in the delivery of care to a patient; it may include an acute care hospital, a home health agency, a nursing home, a rehabilitation unit, and other points of service.

a. healthcare marketplace
*b. continuum of care
c. care transition
d. palliative care network
e. comprehensive care spectrum

2. ch02-002
A/an _____ occurs when a patient has been discharged from a healthcare facility but later has to be admitted again for the same condition.

a. care transition
b. coordination of care
c. bundled payment event
*d. readmission
e. iatrogenic condition

3. ch02-003
The _____ is a delivery model in which care is provided by physician practices with the aim of strengthening the patient–physician relationship. The model seeks to replace episodic care based on illnesses and patient complaints with coordinated care based on a long-term healing relationship.

a. palliative care model
b. bundled payment system
*c. patient-centered medical home
d. independent practice association
e. hospice system

4. ch02-004
A/an _____ is an entity that receives federal support to serve indigent patients, as well as patients with Medicare or Medicaid, in a medically underserved area.

*a. federally qualified health center
b. patient-centered medical home
c. accountable care organization
d. home health agency
e. affordable care center

5. ch02-005
Palliative care is a type of hospice care specifically for terminally ill patients.

a. True
*b. False

6. ch02-006
In a/an _____ system, all services associated with an episode of care are compensated at a predetermined amount and, thereafter, all stakeholders in the chain of care delivery are expected to allocate compensation based on the cost of resources used.

a. volume-based
b. patient-centered medical home
c. affordable care
*d. bundled payment
e. federally qualified health

7. ch02-007
The continuum of care includes which of the following?

a. Hospitals
b. Palliative care settings
c. Nursing homes
d. Home health clinics
e. Rehabilitation facilities
*f. All of the above

9. ch02-009
Moving a patient from a hospital to a nursing home, to the patient's home, or to another facility in the community is an example of what?

a. Duplication of care
b. A readmission

c. Waste
*d. A care transition
e. A healthcare exchange

10. ch02-010
Which of the following represents a way to help prevent readmissions?

a. Patient education and training
b. Improved coordination of care
c. Hospice and palliative care
d. Increased connectivity via telephone and internet
*e. All of the above
f. None of the above

11. ch02-011
Investments in infrastructure may help improve an organization’s processes, but they have little impact on the degree of value delivered.

a. True
*b. False

12. ch02-012
Advances in information technology, electronic medical records, payment reform, multidisciplinary teams, and risk-based contracting are likely to improve the quality of care, but they will also be a key driver of the long-term escalation of healthcare costs.

a. True
*b. False