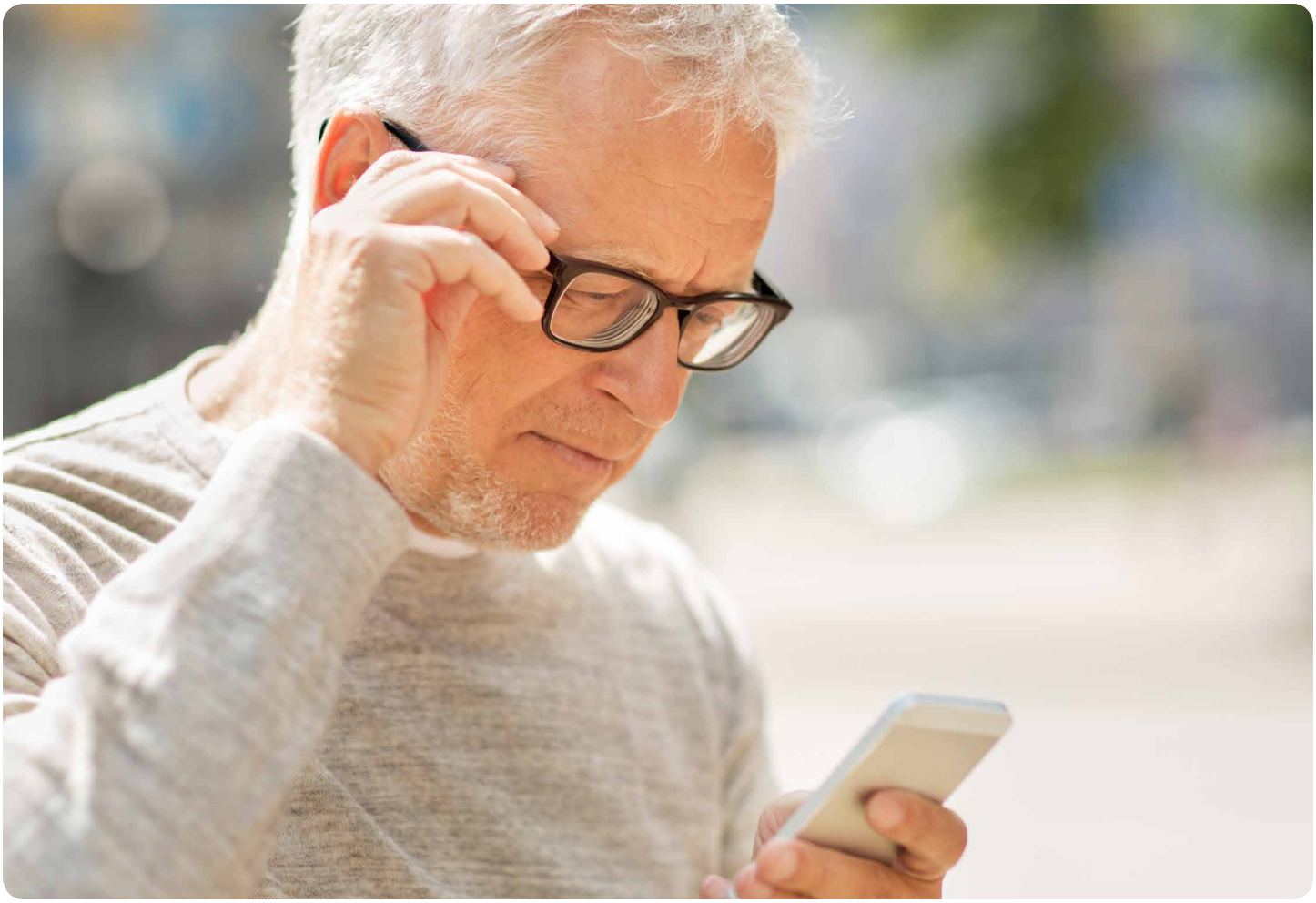

REPORT

NRC Health Transitions Benchmark Report

Reducing readmissions: the secret is in your numbers

nrc HEALTH | Transitions

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NRC Health Transitions Benchmark Report

Reducing Readmissions

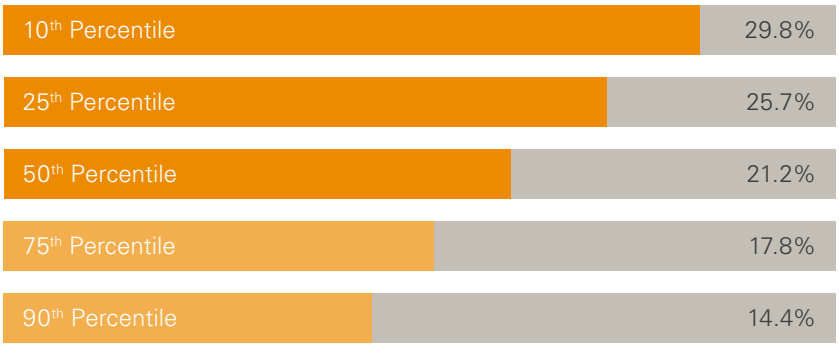
THE SECRET IS IN YOUR NUMBERS
The issue of reducing preventable readmissions is, or at least should be, a top of mind concern for every healthcare executive across the country. The government's campaign to reduce readmissions has resulted in nearly $500 million in fines to date with the amount of reimbursement at risk per hospital significantly increasing over time.

WHERE DOES YOUR HOSPITAL STAND?
While medical centers across the country have been investing extensive financial, management, and staffing resources on strategies to reduce readmissions, the problem has not gotten any better. For the majority, it has actually gotten worse. Fines increased for 1,074 hospitals and 238 new hospitals were fined in the second year of the program. Strategies to improve the delivery of care will not result in a measurable impact if you don't know where to focus. You should know where your organization stands in comparison to other top performing organizations on the three main predictors of a readmission:

- Your patients' understanding of discharge instructions.
- Your patients' adherence to medication.
- Your patients' knowledge of how to follow-up on their care plan.

Ensuring that your hospital can consistently transition patients to their next level of care is the only way to stop the cycle of hospital readmissions.

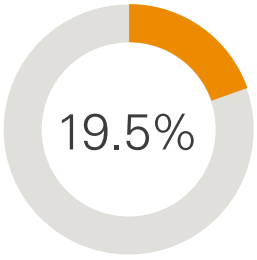
PERCENTILE BREAKOUT
In top performing organizations, less than 17.8% of patients have questions or issues related to their transition post discharge.



Represents the risk assessments of 799,419 patients discharged from 100 hospitals nationwide between Jan. 1 and Dec. 31, 2013.

TARGET EFFORTS
Top performing hospitals monitor transitions in real-time and leverage data to drive process improvement. They are able to set realistic targets and focus resources on improving areas that result in the biggest impact on quality, financial, and patient outcomes. Visibility to this information drives rapid improvement in the hospital's care delivery and discharge process.

LINKAGE TO READMISSION PENALTY
Hospitals in the lowest readmission penalty quartile, with an average 2014 penalty of 0%, have only 19.5% of patients experiencing issues with their transition post discharge, in contrast to hospitals in the highest readmission penalty quartile, with average 2014 penalty of 0.88%, have 24.4% of patients experiencing issues with their transition post discharge.



Lowest readmission penalty quartile

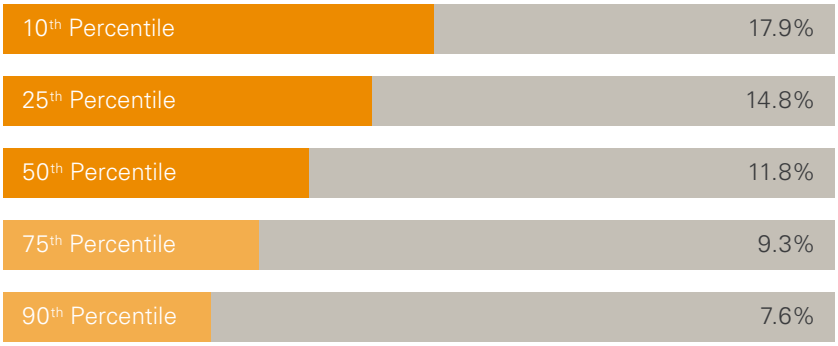
Care Instruction Issues

ARE YOU EFFECTIVELY EDUCATING YOUR PATIENTS ON THEIR CARE INSTRUCTIONS?

Top performing organizations are focused on redesigning their discharge process to ensure that patient education and discharge instructions are not designed in a "one-size fits all" approach, but consider factors such as literacy and cognitive impairments. As the average length of stay has decreased, patients are now being discharged with a higher level of acuity and more complex post discharge care instructions. In order to prevent future readmissions, hospitals need to understand the key failures in their discharge process and monitor improvement in those areas in real-time.

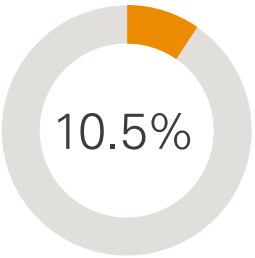
PERCENTILE BREAKOUT

In top performing organizations, less than 9.3% of patients have questions about their care instructions post discharge.



Represents the risk assessments of 799,419 patients discharged from 100 hospitals nationwide between Jan. 1 and Dec. 31, 2013.

Organizations with no readmission penalty, on average, have 10.5% or fewer patients with issues related to care instructions post discharge.



MAXIMIZE YOUR EFFORTS

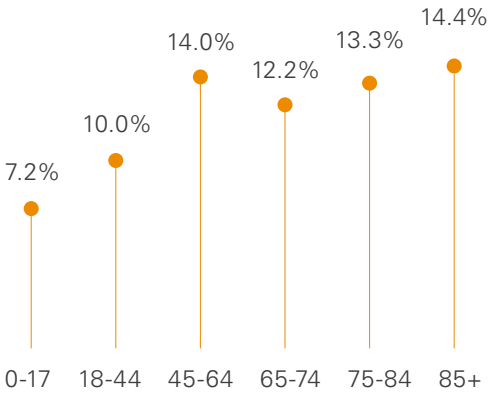
During 2013, NRC Health conducted a text and sentiment analysis of hundreds of thousands of nursing notes in the Transitions database. Each note related to resolving patient issues and concerns post discharge.

This research project identified the following themes from post discharge issues related to care instructions:

- Equipment
- Medication
- Pain Management
- Post-Acute
- Warning Signs/Symptoms
- Wound/Self Care

DIFFERENCES BY AGE

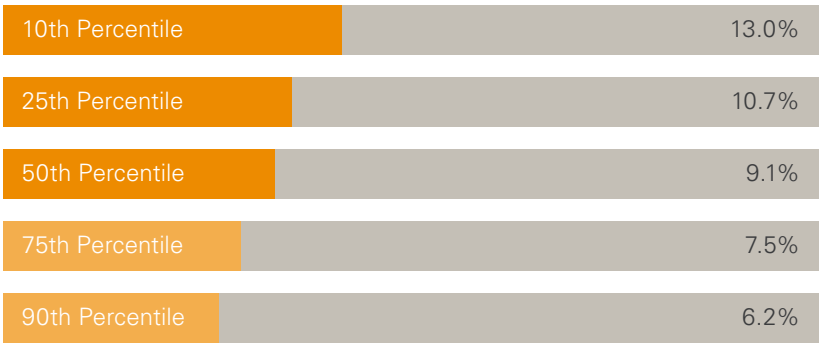
Provided is a breakout of care instruction issues post discharge by age groups.



Medication Issues

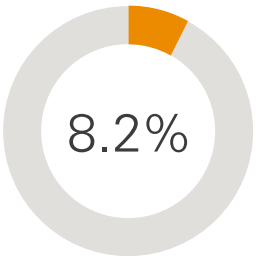
DO YOUR PATIENTS UNDERSTAND HOW TO MANAGE THEIR MEDICATIONS?
Medication compliance is crucial for patients to improve their condition post discharge. Medication compilation is still too fragmented and inconsistent with not enough accountability for the care providers to ensure patients understand their medication. Highly effective hospitals have improved medication compilation through understanding the root cause of their issues and implementing efficient process changes including utilization of non-clinician providers, electronic prescribing systems, patient engagement techniques, and monitoring/reminder systems.

PERCENTILE BREAKOUT
In top performing organizations, less than 7.5% of patients have questions about their medication post discharge.



Represents the risk assessments of 799,419 patients discharged from 100 hospitals nationwide between Jan. 1 and Dec. 31, 2013.

Organizations with no readmission penalty, on average, have 8.2% or fewer patients with issues related to medication issues post discharge.

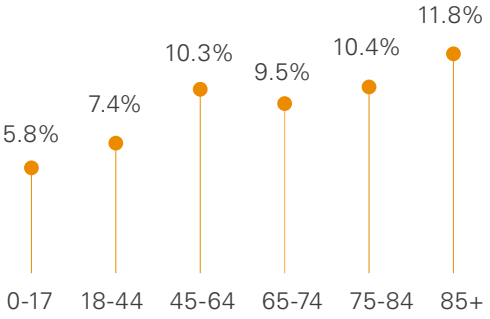


MAXIMIZE YOUR EFFORTS
During 2013, NRC Health conducted a text and sentiment analysis of hundreds of thousands of nursing notes in the Transitions database. Each note related to resolving patient issues and concerns post discharge.

This research project identified the following themes from post discharge issues related to medication compliance:

- Cost/Insurance
- Instructions/Dosage
- Med Reconciliation
- Pain Management
- Side Effects
- Access
- Missing Prescriptions

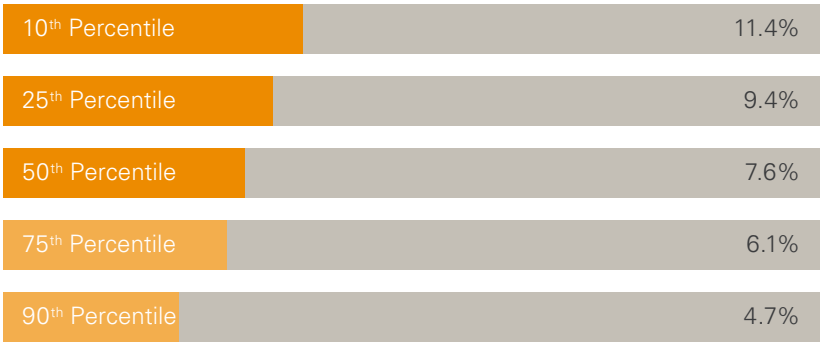
DIFFERENCES BY AGE
Provided is a breakout of medication issues post discharge by age groups.



Follow-Up Care Issues

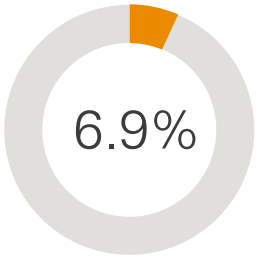
ARE YOUR PATIENTS ADHERING TO THE FOLLOW-UP PROCESS?
Hospitals with lower than average readmission rates focus on strategies to improve the overall quality of internal processes—attacking the root cause of readmissions. They understand and embrace that the key is to ensure the patient has the means and necessary information to make and attend any appropriate follow-up care—even if it increases their costs in the short term.

PERCENTILE BREAKOUT
In top performing organizations, less than 6.1% of patients have questions or issues regarding follow up care post discharge.



Represents the risk assessments of 799,419 patients discharged from 100 hospitals nationwide between Jan. 1 and Dec. 31, 2013.

Organizations with no readmission penalty, on average, have 6.9% or fewer patients with issues related to follow-up care issues post discharge.

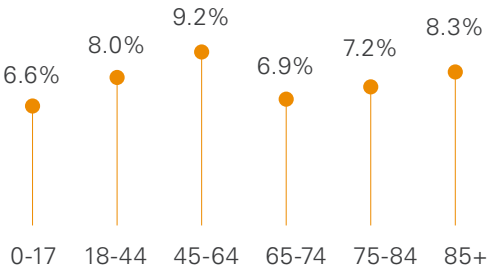


MAXIMIZE YOUR EFFORTS
During 2013, NRC Health conducted a text and sentiment analysis of hundreds of thousands of nursing notes in the Transitions database. Each note related to resolving patient issues and concerns post discharge.

This research project identified the following themes from post discharge issues related to follow-up care:

- Access/Wait Time
- Appointment Details
- Cost/Insurance
- Help Scheduling
- Medical Records
- Referral
- Transportation

DIFFERENCES BY AGE
Provided below is a breakout of physician follow-up issues post discharge by age groups.



Reducing Readmissions

KNOW YOUR HOSPITAL'S NUMBERS

The leading cause and predictor of preventable readmissions is ensuring that patients make a safe transition out of the hospital. While hospital readmissions can never be completely eliminated, they can be significantly reduced. To be highly effective, your organization will need to have a process in place that provides immediate visibility to high risk patients post discharge and real-time metrics that can improve your discharge process.

IDENTIFY HIGH RISK PATIENTS

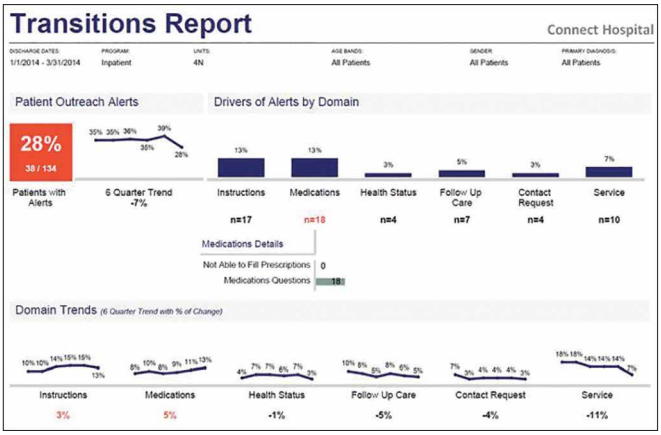
The simplest approach for hospitals to accomplish these two tasks is to CALL patients within 48 hours post discharge to ensure their transition home was safe. When done consistently, post discharge calls are associated with a 40% reduction in readmissions as they prevent a potential readmission and provide real-time feedback your staff can use to improve the delivery of care.

ENSURE RIGHT PEOPLE RESOLVE ISSUES

Realizing that less than 20% of patients are at risk for a readmission, Transitions leverages technology to drive the communication between the hospital and the patient. Transitions contacts every patient within 48 hours post discharge to provide immediate visibility to any patient at risk for a readmission. Should a patient be at risk for a readmission, Transitions alerts the appropriate staff member at your hospital. Detailed patient profiles allow the right staff member to efficiently provide clinical recovery, improving outcomes for both the patient and the hospital.

TRACK AND TREND QUALITY METRICS

In addition to an efficient and effective process, hospitals gain real-time analytics that can be aggregated to proactively address the root cause of readmissions. Through benchmarking and acting on trends, your organization will have the ability to prevent future readmissions.



Actual screenshot of a Transitions Report.

NRC HEALTH TRANSITIONS PROCESS

Realizing that less than 20% of patients are at risk for readmission, Transitions leverages technology to drive the communication between the hospital and the patient.

Patient discharged home

Patient contacted within 24 hours of discharge

Follow-up call if issues are identified

Case Studies

SOUTHEAST MICHIGAN HEALTH SYSTEM
Partnering with NRC Health in 2012, a large health System in Southeast Michigan was able to use technology to effectively and efficiently manage their discharge call program and patient's care transition. It enabled them to systematically reach out to patients post discharge with minimal staff time and commitment. Nurses were able to implement detailed descriptions of more than 30 steps or checks, with potential interventions, that take place at specified points before, during, and after the patient transitions.

Using Transitions ensured that 100% of their patients were contacted within the critical initial 48 hours post discharge—preventing patient readmissions.

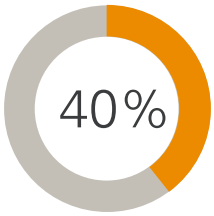
700 BED HOSPITAL
After less than 6 months in partnering with NRC Health, a 700 bed hospital experienced significant increases in all HCAHPS domains. Not only did Transitions provide the organization with a consistent discharge program, but also provided nursing leadership and staff with real-time information to gauge improvement efforts. The nursing teams no longer had to wait 6 weeks to analyze HCAHPS and patient satisfaction in order to act on the patient feedback and reinforce patient-centered behaviors. Instead they were able to use metrics on a weekly, even daily, basis to support improvement efforts and changes in care delivery.

25+ HOSPITAL SYSTEM
After years of investing extensive resources to create an infrastructure to support post discharge calls and mandating staff hours to ensure they were done, a large national health system, despite seeing significant impact on quality and patient satisfaction outcomes, could not make a business case to support the costs of the program. After much consideration and in-depth research, the system knew they needed to rely on Transitions innovation and technology to bridge the gap between the cost of the program and the desired patient outcomes.

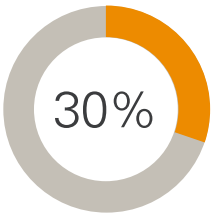
The 25+ hospital system has an average of 150,000 annual inpatient discharges and 645,000 annual emergency department visits. Therefore, more than 795,000 patients would need a follow-up call post discharge.

With Transitions, the health system is confident that every patient from more than 250 patient care units across the system receive a follow-up call. As a result of their partnership with NRC Health, the health system saves an estimated $2.9 million each year.

of patients contacted within 24 hours



reduce readmissions



improve hcahps overall rating

save $2.9 million in costs

ABOUT NRC HEALTH TRANSITIONS

NRC Health is committed to providing the technology to healthcare organizations to reduce readmissions and improve the patient experience. NRC Health offers the largest database in the nation on patient care transitions, advanced analytics, and a suite of multi-channel communications tools. Transitions is a division of NRC Health, which partners with over 2,000 hospitals across the US and Canada.

ABOUT NRC HEALTH

NRC Health enables healthcare organizations to illuminate and improve the key moments that define an experience and build trust. Guided by a uniquely empathic heritage, proprietary methods, and holistic approach, we help our partners design experiences that exceed expectations and inspire loyalty among patients, residents, physicians, nurses, and staff.

NRC Health helps healthcare organizations better understand the people they care for and design experiences that inspire loyalty.

FOR QUESTIONS OR ADDITIONAL INFORMATION

Jackie Stevens
JStevens1@nrchealth.com

NRC Health
1245 Q Street
Lincoln, NE 68508
800-388-4264
nrchealth.com