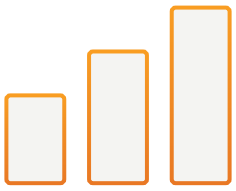


Building an effective discharge call program

Identifying clinical and service recovery opportunities in real-time

nrc HEALTH

Human Understanding

Behind every person is a story...

The roadmap

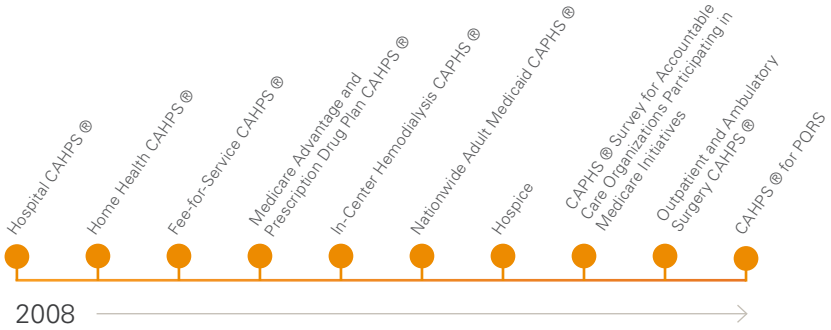
Industry initiatives

Improving the patient experience and reducing preventable readmissions are two issues that are, or at least should be, top of mind concerns for every healthcare executive across the country.

1—Improving patient experience

Striving to provide excellent patient-centered care is not only the right thing for hospitals to do, it's detrimental if they don't. As of fiscal year 2015, hospitals either gained or lost up to 1.5% of reimbursement based on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. In addition to increasing the amount of hospital reimbursement at risk to 2%, the Centers for Medicare and Medicaid Services (CMS) will also continue to expand the service lines included in the Value-Based Purchasing initiative.

CMS SURVEY EXPANSION

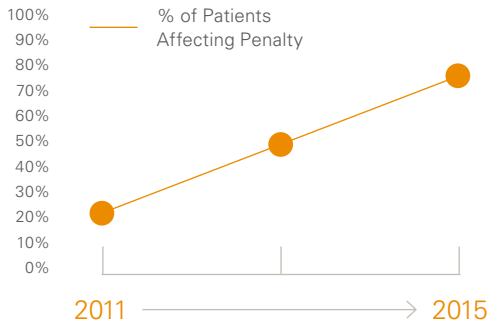


2—Reduce readmissions

In October 2012, the government's campaign to reduce readmissions resulted in over $500 million in fines to date with the amount of reimbursement at risk per hospital significantly increasing over time.

The penalty program is among the toughest of Medicare's efforts to pay hospitals for the quality of their performances rather than merely the number of patients they treat. Unlike other new programs, including Value-Based Purchasing, which ties reimbursement to quality indicators and HCAHPS scores, the readmissions program offers hospitals no rewards for improvements.

READMISSION REDUCTION PROGRAM



OCTOBER 2014
Readmission Penalties Increase to 3%

OCTOBER 2015
Readmission penalties increase to $428 million, up from $227 million in 2014

HCAHPS star rating

Star Rating	Number of Hospitals
★	101
★★	582
★★★	1414
★★★★	1205
★★★★★	251

Readmission penalties

1074	number of hospitals whose readmission penalty did increase
238	number of hospitals not fined
4/5	number of hospitals fined in nearly half of states across the country
2638	number of facilities being penalized for readmissions

A model to improve the delivery of care and the patient experience

A leading factor in improving the overall patient experience and preventing readmissions is ensuring that patients make a safe transition out of the hospital.

A recent study conducted at the Duke University Fuqua School of Medicine found that effective discharge planning is highly correlated to improvement in HCAHPS scores as well as associated with lower readmission rates. The key to being highly effective at discharge planning is through efficient communication with ALL patients post-discharge. Following up with every patient post-discharge provides organizations with an immediate opportunity to provide clinical or service recovery and real-time patient feedback that can improve the delivery of care for future patients.

Contact 100% of patients

While the majority of patients will make a safe and healthy transition from the hospital, research shows that nearly 20% percent of patients will require additional transition support. However, high patient volumes and low availability of non-patient care nursing time make it nearly impossible to reach out to all patients. In addition to contacting every patient, organizations need a process in place that allows staff to target specific patient populations differently. For example, chronically ill and high risk patients require follow-up calls that address how to continue their care plan outside the hospital, which often involves case management. While follow-up calls to moderate and low risk patients need to focus on mitigating risk and ensure the patient is satisfied with the care and overall hospital experience.

% THAT MAKE A SAFE TRANSITION HOME

80%
of patients

% THAT REQUIRE TRANSITION SUPPORT FOR CLINICAL OR SERVICE NEEDS

20%
of high risk patients

High risk

May be included in a discharge call program, but can be excluded if actively managed by Case Management post-discharge.

10–20%

Moderate risk

Always included in a discharge call program with primary goal of identifying clinical risks with small number of higher risk patients transitioned into Case Management.

40–50%

Low risk

Always included in a discharge call program with primary goal of service recovery with limited percentage of patients experiencing clinical complications.

40–50%

Create a standardized process

In order to maximize resources and see results, healthcare organizations must have a systematic process in place across all patients, areas, and departments. Every patient needs to receive a high quality follow-up call within 72 hours of discharge that addresses the key areas that often lead to health complications.

Standardizing the discharge call process is the only way to ensure that calls are made timely and consistently and that patient feedback is quantified and used for rapid process improvement.

Ensure the right people are managing issues

Post-discharge calls immediately identify whether and what clinical and/or service issues patients are experiencing. When executed efficiently, the discharge call process will also allow organizations to effectively allocate resources to ensure that the correct staff member is following up with the right patients.

Rather than requiring numerous, sometimes hundreds of clinicians to be trained to conduct discharge calls, organizations will have better outcomes if they leverage technology to assess patients first, then focus their clinical and service resources to only follow-up with the small percentage of high-risk or dissatisfied patients. In addition, highly effective organizations have steps in place to triage higher risk patients to additional levels of care throughout the hospital or healthcare system.

Improving the discharge process using analytics

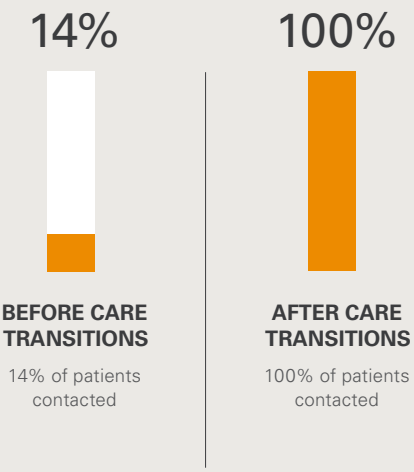
Unlike patient satisfaction surveys, patient discharge calls take place in close proximity to the time of service. Therefore, they provide more accurate information regarding:

- The patient experience
- The discharge process
- Transitional care needs
- Opportunities for process improvement

Through contacting every patient and having the right people managing patient issues, organizations have access to an invaluable database of real-time patient feedback on care transitions. These metrics provide immediate visibility to gaps in the delivery of care, driving process improvement in areas such as physician communication, medication reconciliation, and the discharge process.

Contact rates with an internal discharge call process vs. with the NRC Health Care Transitions solution

Organizations that allow units/departments to decide how follow-up calls are conducted reach significantly less patients than those that standardize their approach across the system.



The NRC Health Care Transitions solution

The Care Transitions solution leverages technology to drive effective communication between healthcare providers and patients in the critical 24-72 hours post-discharge by:

- Providing immediate visibility to patients at risk for a readmission
- Reporting patient level assessment data and historical patient profiles so that the patient's issues can be resolved efficiently by the appropriate member of the care team
- Tracking, trending and benchmarking to isolate the key areas for process improvement allowing organizations to implement changes and reduce future readmissions

NRC Health ensures that your discharge call program contacts 100% of patients within the critical initial 24-72 hours post-discharge. Through needs-based communication the Care Transitions solution leverages thorough and comprehensive outreach to identify and manage high-risk patients to reduce readmissions, increase patient satisfaction, support safe transitions, and create Human Understanding™.

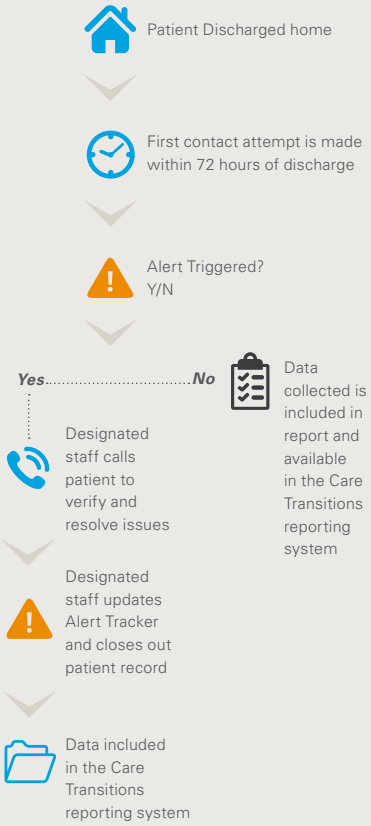
Preference-based communications for real-time feedback

Realizing that only 20% of patients require additional attention, the NRC Health Care Transitions solution leverages multi-channel outreach to drive communication between the hospital and the patient. With Care Transitions, hospitals gain immediate visibility to high-risk patients, the ability to ensure the most appropriate staff member addresses patient issues, and access to detailed patient profiles that drive efficient clinical and service recovery.

Leveraging analytics for process improvement

Unlike satisfaction surveys, the NRC Health Care Transitions solution ensures that patient discharge calls take place in close proximity to the time of service. They provide more accurate information about the patient experience, the discharge process, issues that can impact patient care, opportunities for improvement and areas where improvements are being made. Through utilizing the Care Transitions solution, organizations are able to collect data and push reports to leadership, unit managers, and other key decision makers. As changes are made, the organization will continue to have data that supports the impact of the improvements.

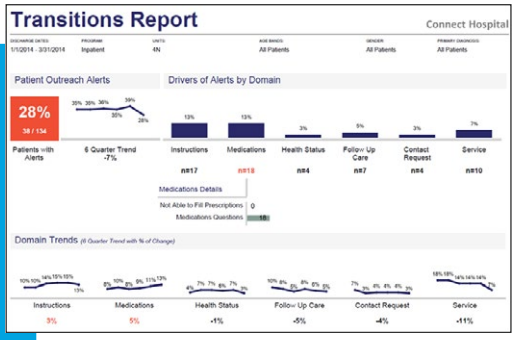
NRC Health Care Transitions process and alert management

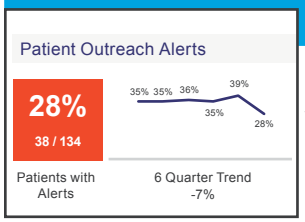


1. TRANSITIONS REPORT:

Quality metrics and key drivers leading to patient clinical and service issues

Pushed to Chief Nursing Officer, Nursing Leadership and Readmission Committees



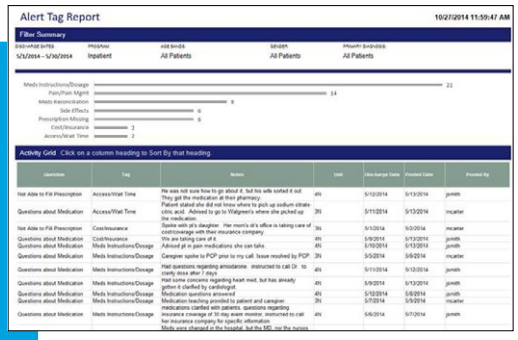


Patient Outreach Alerts

2. ALERT TAG REPORT:

Text analysis of patient feedback to uncover gaps in the delivery of care and opportunities for process improvement

Pushed to Chief Quality Officer, Quality Directors, and Readmission Committees



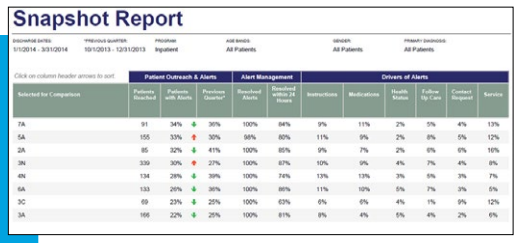
He was not sure how to go about it, but his wife sorted it out. They got the medication at their pharmacy.
Patient stated she did not know where to pick up sodium citrate-citric acid. Advised to go to Walgreen's where she picked up the medication.
Spoke with pt's daughter. Her mom's dr's office is taking care of cost/coverage with their insurance company.
We are taking care of it.
Advised pt in pain medications she can take.
Caregiver spoke to PCP prior to my call. Issue resolved by PCP.
Had questions regarding amiodarone. Instructed to call Dr. to clarify dose after 7 days
Had some concerns regarding heart med, but has already gotten it clarified by cardiologist.

Meds Instructions

3. SNAPSHOT REPORT:

Overview of hospital and unit performance including trending and benchmarking on transition issues

Pushed to Chief Nursing Officer, Chief Quality Officer, and other Senior Leadership



Patients Reached	Patients with Alerts	Previous Quarter	Resolved Alerts
91	34% ↓	36%	100%
155	33% ↑	30%	98%
85	32% ↓	41%	100%
339	30% ↑	27%	100%
134	28% ↓	39%	100%

Patient Outreach/Alerts

NRC Health Care Transitions benchmark data

1 in 5

Patients readmitted within 30 days post-discharge

Patients need assistance with making follow-up appointment

Patients with questions or concerns regarding medications

Patients don't understand their discharge instructions

Additional reports

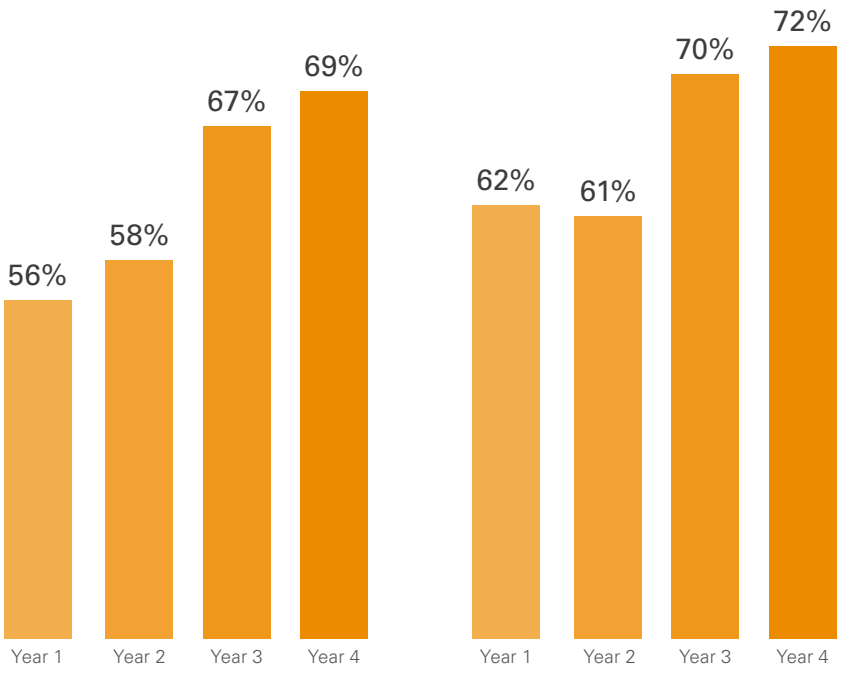
- Compliments Report
- Accountability Report
- Unit and Leadership Dashboard Reports

Partnering with NRC Health: a return on investment

A large driver of patients' overall satisfaction and an organization's readmission rates is whether or not a patient makes a safe transition from the hospital. Therefore, hospitals and health systems that have a standardized discharge call process in place have significantly higher HCAHPS scores than those that do not have a standardized discharge call process in place.

For example, after implementing the Care Transitions solution, a 500 bed hospital in New York saw significant impact on HCAHPS scores and gained the ability to collect accurate, quality feedback from patients to drive process improvement and service recovery.

EFFECTIVENESS OF THE CARE TRANSITIONS SOLUTION ON HCAHPS SCORES



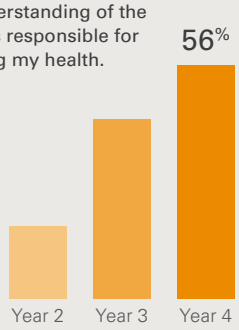
Hospital rating

Would recommend

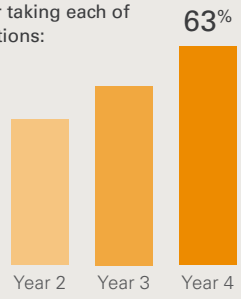
HCAHPS improvement

Post-discharge calls easily identify gaps in the discharge process and barriers that patients face post discharge. **Therefore, they have the most significant impact on the following HCAHPS questions:**

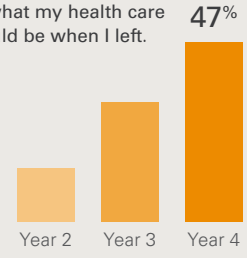
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.



When I left the hospital, I clearly understood the purpose for taking each of my medications:



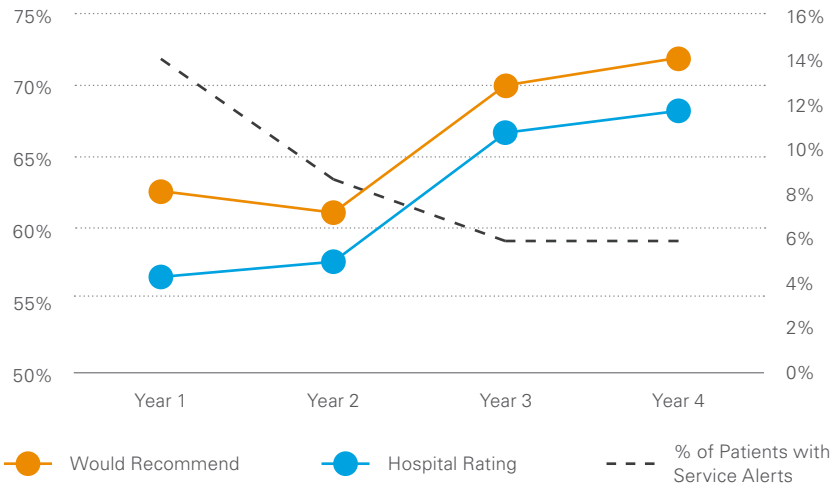
During this hospital stay, the staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.



Using Data for Process Improvement

Effective post-discharge phone call programs also provide organizations with an invaluable database of patient feedback. When captured and executed on, this information leads to improved processes and safer patient transitions over time, resulting in a better delivery of care model, higher HCAHPS scores, and a reduction in high risk patients over time.

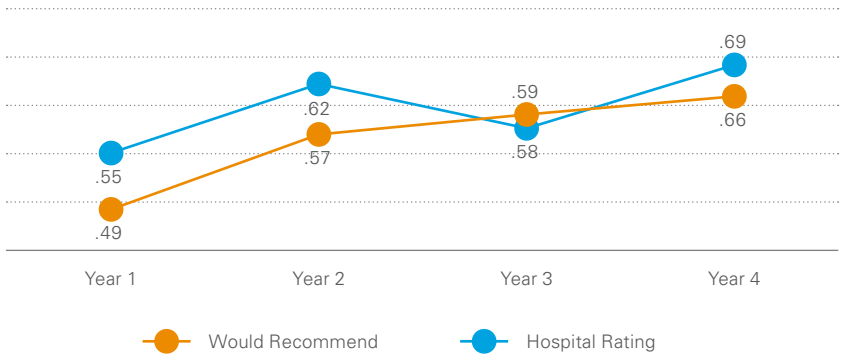
NRC HEALTH CARE TRANSITIONS HCAHPS IMPACT ON IDENTIFYING PATIENTS WITH SERVICE ISSUES



Service recovery

The NRC Health Care Transitions solution provides a standardized, systematic approach where leadership can be confident that the most appropriate staff is responsible for any clinical and/or service recovery. Staff are chosen based on their skill set and provided with additional training to ensure they are able to listen, acknowledge, and rectify any issues.

EFFECTIVENESS OF SERVICE RECOVERY USING NRC HEALTH V



About NRC Health

NRC Health has helped healthcare organizations illuminate and improve the moments that matter most to patients, residents, physicians, nurses, and staff for over 40 years.

Our empathetic heritage, proprietary methods, and holistic approach enable our partners to better understand the people they care for and design experiences that inspire loyalty and trust.

Contact us for additional information

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nrc HEALTH | Human Understanding
Behind every person is a story...