Two Care Coordination Strategies That Are **Improving Patient Outcomes**

Medically complex patients tend to experience longer recovery journeys and are more likely to readmit to the ICU after hospitalization. For these patients, it is essential to reduce setbacks and readmissions. Learn about two care coordination strategies that can improve recovery, and how Kindred Hospitals are taking them a step further.

Contributors to Recovery Setbacks

1 Adverse Events

An average of 10% of patients in a hospital will experience at least one adverse event, around 50% of which are preventable.[1]

2 Discharge Delays

Studies have demonstrated an association between unnecessary discharge delays and negative outcomes such as mortality, infections, depression and reduced patient independence.[2]

3 Avoidable Readmissions

High readmission rates cost hospitals $521 million in penalties in 2022, with Medicare reducing its payments to 47% of all hospitals.[3]

Strategy 1: Internal Coordination

Strategy

Bring together specialists from different departments within a provider setting for information sharing and development of collaborative care plans

Benefit

Reduces the risk of adverse events related to miscommunication between caregivers

Kindred's Approach

Kindred's interdisciplinary care teams of physicians, ICU-level nurses, respiratory therapists and rehab specialists break down silos by meeting at the bedside daily to discuss goals, milestones and progress with the patient and family.

Strategy 2: External Coordination

Strategy

Facilitate communication between providers and payers about patients' clinical needs and barriers to discharge

Benefit

Reduces discharge delays and the risk of readmission associated with a misalignment of medical need and level of care

Kindred's Approach

Kindred's care coordination meetings bring payers and Kindred case managers together for real-time discussions on patient conditions, appropriate care pathways and solutions to discharge barriers.

If you have a patient in need of continued acute care after a hospital stay, call a Kindred Clinical Liaison for a patient assessment. Our experts will help you determine whether an LTACH stay is appropriate for your patient. If you are unsure of who your Kindred representative is, please feel free to contact us via recoveratkindred.com and speak with a Registered Nurse who can assist.

References:

1.https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3335-z
2.https://pubmed.ncbi.nlm.nih.gov/28898930
3.https://khn.org/news/article/hospital-readmission-rates-medicare-penalties

Kindred Hospitals