> I truly value the relationships I have with Kindred leaders because they are committed to optimizing patient care, improving hospital throughput and efficiency, and enhancing processes in the spirit of continuous improvement.
>
> - Alistair Aaronson, MD, MHA, FACP
> *Division Medical Director, Care Management and CDI Providence South Division*

Care Coordination: Expediting ICU Discharges for LTACH-Appropriate Patients

As America's hospitalized patients become increasingly complex, so does their treatment. Today, over 27% of American adults have two or more serious chronic conditions, and that percentage is expected to grow as the population ages.[1] When medically complex patients require hospital care, they tend to experience longer recovery times than other patients do and are more likely to readmit to the ICU.[2,3]

Kindred Hospitals, a network of long-term acute care hospitals (LTACHs), is focused on reducing lengths of stay in the ICU and readmissions for medically complex patients by enhancing our care coordination. By working closely with case managers and discharge planners in the ICU to identify LTACH-appropriate patients, our clinical liaisons can help expedite discharges, to the benefit of both patients and hospitals.

Reducing Discharge Delays

Studies have demonstrated a link between unnecessary discharge delays and negative outcomes such as hospital-acquired infections, reduced patient independence, and an overall reduced quality of life.[4] An extended ICU stay is also a risk factor for post-intensive care syndrome, which includes symptoms such as ICU-acquired weakness (ICUAW), cognitive deficits, and anxiety and depressive disorders.[5] In fact, as many as 55% of patients remaining in the ICU for 7-10 days develop ICUAW.[6]

Kindred Hospitals
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For medically complex patients, particularly those requiring mechanical ventilation, it is critical that they begin receiving care at a long-term acute care hospital as soon as possible. As one study indicates, a one-day delay in discharge to the long-term acute care hospital after intubation is associated with an 11.6% reduction in the odds of weaning.[7]

With increased care coordination, Kindred Hospitals can help identify patients who may be ready to start receiving specialized acute care. Facilitating timely transitions also opens critical care beds faster, improving hospital throughput and easing emergency department boarding challenges.

Reducing Readmissions

Approximately 27% of 30-day post-discharge hospital readmissions are considered avoidable.[8] When medically complex patients transfer to LTACHs, they receive specialized acute care and rehabilitation that can reduce their risk of readmission. This is supported by data that breaks down readmission rates by patient acuity, as measured by Hierarchical Condition Category scores.[9] The data show the average readmission rates for patients in the High or Very High HCC tiers (higher acuity) are about 50% lower at LTACHs than at traditional hospitals.[10]

Reducing readmission rates is also an important strategic goal for hospitals. Readmissions cost an estimated $57.7 billion annually in care, in addition to penalties incurred as part of CMS' Hospital Readmissions Reduction Program.[11] In 2023, CMS applied penalties worth $320 million for high readmission rates.[12] Hospitals therefore benefit from ensuring that patients receive the level of care that most closely aligns with their medical needs.

Patient Satisfaction

Finally, coordinating for early identification of LTACH appropriateness affords all parties extra time to plan for discharge, improving patient satisfaction. Patients and families are given ample time to consider their options for discharge and take a hospital tour before the discharge order is formally written. Additionally, LTACHs can initiate authorizations proactively and minimize risk for denial management or, when unavoidable, work through the appeal process expeditiously for timely admission.

> Kindred has been a valued partner to us in coordinating care for the patient. Physicians don't always know the extent of LTACH capabilities, and that's why it's helpful to have a liaison that's following along and able to real-time inform the physicians and clinical teams what LTACHs can do.
>
> - Daniel Del Portal, MD, MBA
> *SVP, Medical Operations and CCO, Temple University Health System*

Benefits of Choosing Kindred Hospitals

When LTACH-appropriate patients choose to transfer to a Kindred Hospital, patients and physicians benefit from the following:

Authorizations: We have a team of authorizations specialists who are trained in payor-specific criteria and turnaround times for improved first-pass authorizations. We also have robust denials-management capabilities that help patients gain access to the hospital of their choice.

Expert Care: Patients at Kindred benefit from physician-led interdisciplinary care and specialized rehabilitation. Our care includes:

Interdisciplinary care team bedside rounds: Kindred Hospitals' physician-led interdisciplinary care teams gather at the patient's bedside to discuss patient goals, milestones, and progress, and to provide education and answer questions – improving patient and family experience and outcomes.

Early Mobility: Kindred patients receive rehabilitation therapy, to the degree they are able, from physical and occupational therapists, as well as speech-language pathologists, even while receiving acute care. Our Move Early Program aims to incorporate movement into the recovery plan as early as is safe, even for patients on mechanical ventilation.

Certifications from The Joint Commission: Demonstrating our dedication to excellence in care, each of our hospitals has received at least one disease-specific care certification from The Joint Commission, ensuring a standardized, evidence-based approach to treatment and performance improvement.

AfterCare Program: Through our unique post-discharge program, representatives follow up with patients after they leave our hospital to answer questions about discharge orders, medications, or follow-up appointments.

Physician Updates: Kindred physicians offer referring physicians real-time updates, with patient consent, as well as regular performance reporting and discussion.

Medically complex patients who have long ICU stays are at an increased risk of adverse events and readmissions. It is critical that healthcare systems have strategies in place for addressing this growing concern. Kindred Hospitals' focus on improved care coordination is designed to efficiently and effectively help such patients move to the most appropriate care setting as soon as possible, so that they can achieve optimal recovery and return to the lives they love.

To learn more about our care, contact your Kindred Clinical Liaison, visit kindredhospitals.com or scan the QR code.

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