Coordinating Care to Efficiently Move Complex Patients Through the Continuum

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 and readmissions for medically complex patients by enhancing our care coordination. By working closely with ICUs, payors, and downstream post-acute care providers, we can help move complex patients safely and effectively though the care continuum.

Kindred Hospitals
Empowered by ScionHealth

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]

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.[6]

With increased care coordination, Kindred Hospitals can help identify patients who may be ready to start receiving specialized acute care, reducing unnecessary time spent in costly ICUs.

Reducing Readmissions

Approximately 27% of 30-day post-discharge hospital readmissions are considered avoidable.[7] 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.[8] 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.[9]

Reducing readmission rates is also an important strategic goal for payors, as readmissions cost an estimated $57.7 billion annually in care.[10] **Payers 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, proactive initiation of the authorizations process can help ensure timely admission.

$57.7B

Estimated annual cost of readmissions

11.6%

Reduction in the odds of weaning with a one-day delay in discharge

Benefits of Choosing Kindred Hospitals

Expert Care: When LTACH-appropriate patients choose to transfer to a Kindred Hospital, patients 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.

Care Coordination Meetings: Kindred Hospitals has developed a program of care coordination meetings with payors that have many patients at Kindred.

During this time, medical directors and utilization management nurses can ask Kindred case managers specific questions about each of their patients in Kindred's care, allowing them to get a more complete picture of the patient's needs.

Kindred's care teams can also discuss barriers to discharge, and payors can provide network access where necessary to facilitate patient advancement.

In some cases, these discussions may lead to care conferences between Kindred case managers, the payor, and the patient and family in which the entities can answer the family's questions and help guide the patient along the path to recovery.

Kindred Hospitals' focus on improved care coordination is designed to efficiently and effectively help complex 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, visit kindredmanagedcare.com or scan the QR code.

1. https://www.cdc.gov/pcd/issues/2020/20_0130.htm
2. https://pmc.ncbi.nlm.nih.gov/articles/PMC9583235/
3. https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-020-01867-3
4. https://pmc.ncbi.nlm.nih.gov/articles/PMC11210572/
5. https://www.accjournal.org/journal/view.php?number=1522
6. https://pubmed.ncbi.nlm.nih.gov/33761903
7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080556/
8. https://www.advisory.com/blog/2018/04/reimbursement
9. The Advisory Board. The Post Acute Care Pathways Explorer. State Average Outcomes by HCC Score Tier. HCC tiers include Medicare FFS patients with a total HCC score in the following ranges: 'Low' between 0 and 2, 'Mid' greater than 2 and less than or equal to 4, 'High' greater than 4 and less than or equal to 6, and Very High' greater than 6. Accessed March 2025.
10. https://hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp; 3.8 million adult hospital readmissions within 30 days, with an average readmission cost of $15,200.

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