# CONTINOUS CARE MANAGEMENT

### **Kauvery Hospitals**

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### **Details of Solution**



Three key stages of care delivery

### **Post-Discharge**

#### Coordinate

post hospital care across all settings

# Take Immediate action

to schedule follow up appointments with physicians

### Engage

Patients and their families to play active roles in managing their health



## **Details of Solution**

# **Dedicated Care Coordinators**

Our professional, trained, and qualified staff provides comprehensive care coordination and planning following hospital discharge to deliver appropriate, timely care interventions.

#### **Personalised Care Plan**

Our Care Coordinators develop robust transitional care plans that ensure coordination and continuity of healthcare as the patient's needs change during the course of a chronic or acute illness. We help individuals stay independent, and educate family and caretakers on the importance of adherence to the care plan to minimize unnecessary rehospitalizations.

### Al powered tech platform

Al powered platform that helps assess the condition of the patient, and provide alerts in case of deteriorating condition. The platform predicts the next touch point date to connect with the patient and also predicts the set of clinical symptoms to ask the patient at every touch point, where it automatically categorises the symptoms whether they are "at-risk" or "mild"



# **Project Implementation**

Feb 2021

Launched POC in
Cardiology Dept,
Kauvery Heart City

April 2021
Full fledged
implementation
with streamlined
operations

June 2021
Launched
initiative in other
departments –
Urology,
Oncology, Neuro,
Otrho

Nov 2020

Project Initiation and Technology discovery Jan 2020

finalisation

Project approach

Doctor's buy-in and appropriate care givers identification

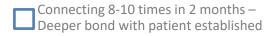
- Managing advice given

- Training for remote management

# **Impact**



# Improvement in Patient Satisfaction



- Address requests, queries and be a single point of contact with easy access
- NPS score improvement 20% higher than average



#### Reduce re-admission rates



- Reduces cost for patient by avoiding multiple hospital visits
- 52 interventions in 4 months
- Avg re-admission rate at 3.5% vs national average of 12.6% in the US for CABG



#### **Reduce mortality rates**

- By avoiding unnecessary complications, reducing risk of critical escalation
- Impact on mortality can be observed in longer term

Making quality healthcare affordable



# Sustainability and Scalability

### Sustainability

- Cost: The technology cost of continuing the initiative is self sustainable, as we incur cost per patient, and we pay only as per the volume of patients we wish to cover
- Manpower: leveraging our existing nursing staff, who for personal reasons such as pregnancy, would be required to stay at home. We have equipped such nurses with the infrastructure needed for remote work, and on-boarded them as Care Executives.

### Scalability

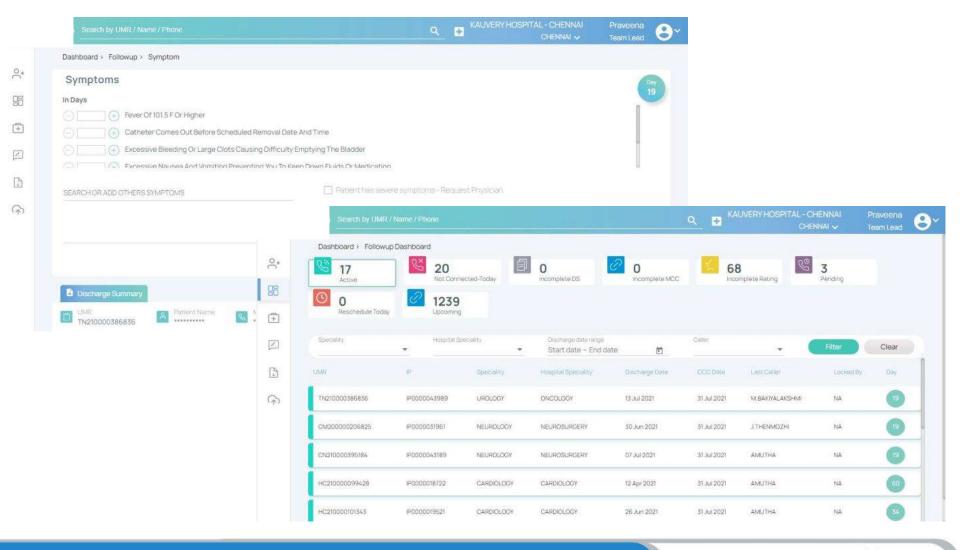
- Doctor buy-in -> Confirm care protocol -> Care executive training -> Metrics tracking
- Ever month addition of new specialty across units
- With protocol and manpower process can be established across any hospital



# **THANK YOU**



### Annexure





### Snapshot



Туре	Count
No of Discharge	2085
No of Patients connected	3297
No of Readmissions	55
No of Leakages	23
No of Death Outside	22
No of Physician Escalation and avoided Complications	52
No of Feedbacks	84

