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

symptoms reduces re-admission

- 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

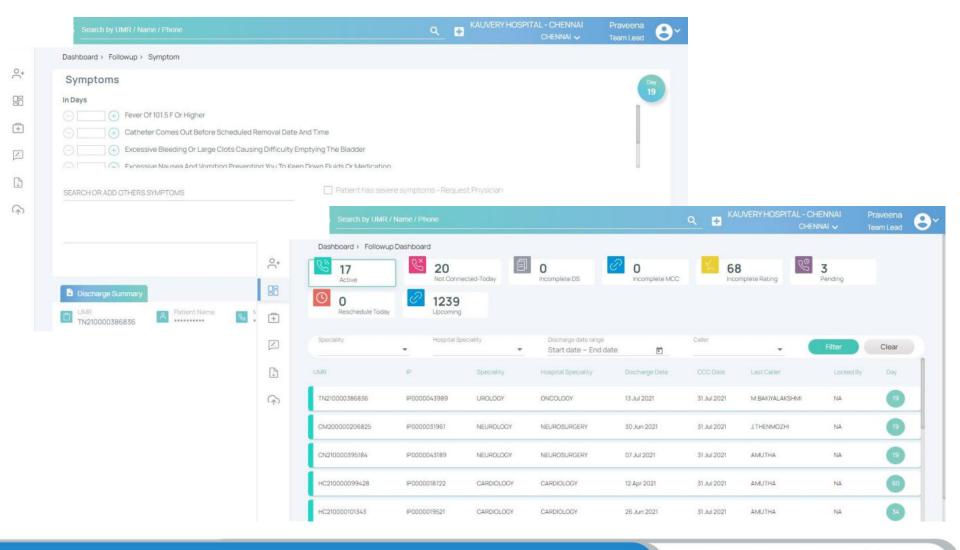
- Doctor buy-in -> Confirm care protocol -> Care executive training -> Metrics tracking
- Ever month addition of new specialty across units
- With protocol and manpower process can be established across any hospital



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

