LAKEVIEW / CLINICAL PARTNERS

Coordinating care during and after a complex hospital stay

When several teams share responsibility for one person, small gaps can affect a transfer. Use this guide to connect the bedside plan, the receiving team, the family and the payer.

What coordination protects against

A medically complex person may have several chronic conditions, a new acute illness and multiple clinicians changing treatment at the same time. The earlier paper cited a U.S. adult estimate of more than 27% with two or more serious chronic conditions. At the bedside, the practical question is which conditions interact today. A medicine, a fluid limit or the timing of a therapy session can change the plan for more than one team.

The paper discussed three different setbacks. An adverse event is harm associated with care. A discharge delay may occur after the person is clinically ready but before transport, coverage, equipment or a receiving bed is in place. A readmission is a return to hospital after discharge. These measures answer different questions and should be tracked separately.

Historical research cited in the paper estimated that about one in ten hospitalized patients experienced an adverse event, about half of those events might be avoidable, and about 27% of 30-day readmissions in the population reviewed might be avoidable. The paper also cited an estimated $26 billion in annual readmission costs and $521 million in 2022 Medicare penalties. These figures come from different sources and periods. Avoid using them as current local rates.

Bring the bedside teams together

When clinicians work from separate plans, an otherwise reasonable treatment may conflict with another part of care. For example, respiratory therapy may plan a breathing trial while rehabilitation staff are preparing a transfer to the chair. Nursing can identify recent changes in alertness or medicines. The team can choose the time, sequence and assistance that fit the person.

The earlier paper described interdisciplinary teams that included physicians, bedside nurses, respiratory therapists, dietitians and rehabilitation staff. Research cited in it associated team-based ICU care and coordinated long-term ventilator weaning with improvements in selected outcomes, including time on a ventilator. The findings are specific to the studies and how care was delivered.

Invite the person and their chosen family member to describe what has changed or what remains unclear. Explain the immediate goal, the evidence of progress and what would change the plan. Document who is responsible for the next assessment. Ask the patient or caregiver to describe the plan in their own words, with an interpreter or communication aid when needed.

Connect the current and receiving teams

The sending team knows the recent history. The receiving team needs to know what it must safely do on the first shift. Send the active medication list and last doses, lines and devices, respiratory support, wound plan, precautions, nutrition orders, current function, pending results and the name of the clinician who will follow them. Include the patient’s own goals and the caregiver’s training or availability.

The paper described two problems that can appear similar. One person may be ready for a lower level of care but waiting for a bed, equipment or a payer decision. Another may still need hospital care but face pressure to move before the next setting can provide it. State the reason for the delay explicitly, the evidence supporting the proposed level and who can resolve the outstanding question.

Include the payer and family when a barrier persists

In the historical program, payer medical directors and utilization management nurses met with case managers to review individual clinical needs and network access. A conference involving the patient, family, provider and payer could address a remaining obstacle. That description is an example of coordination from the archived paper.

For an individual referral, ask for the specific authorization status and the contact for the next decision. If network access, a special accommodation or an available bed is the issue, record the alternatives being considered. If medical necessity is disputed, ask which information is missing and who can provide it. Give the family a clear next update even if a decision is still pending.

Questions to close a care conference

- What treatment still requires this level of care, and what would signal readiness for the next setting?
- Has the proposed receiving team confirmed it can deliver the ordered treatment and obtain the equipment?
- Which follow-up tasks remain open, who owns each one, and how can the patient or caregiver reach that person?
- What risks or questions did the patient or family identify that are missing from the transfer plan?

Practical details for the transfer record

Make the treatment record specific enough that the receiving clinician can continue care safely. Include why the medicine was prescribed, the last time it was given and the next expected dose. For oxygen, ventilation, IV access, nutrition or wound therapy, state the current order and the equipment that must be ready on arrival.

Separate results that are final from results that remain pending. Identify the clinician responsible for reviewing a result after transfer and a way for the receiving team to obtain it. If a specialist recommends follow-up at a particular interval, include the reason, timing and how the appointment will be arranged.

When a patient is ready for a lower level of care but a bed or service is unavailable, record what the patient needs while waiting and when the constraint will be checked again. If the person instead needs continued hospital-level care, explain which treatment or monitoring requirement makes that necessary.

The historical paper’s spending discussion also drew on a secondary estimate of readmission costs and reporting on fiscal-year 2022 Medicare penalties. Neither amount measures the cost of a specific transition. For a local review, start with the actual affected group, event definition, payment source and follow-up window.

Reading behind the original brief

https://www.cdc.gov/pcd/issues/2020/20_0130.htm

https://pmc.ncbi.nlm.nih.gov/articles/PMC7392362/

Peer-reviewed evidence on the frequency, types, consequences and preventability of adverse events during hospitalization. The scoping review is indexed by the National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/29973258/

https://pubmed.ncbi.nlm.nih.gov/28898930/

https://pmc.ncbi.nlm.nih.gov/articles/PMC3080556/

https://pmc.ncbi.nlm.nih.gov/articles/PMC4526935/

Research on how teams work together in an intensive care unit, including communication, leadership and coordination across clinical disciplines. https://pubmed.ncbi.nlm.nih.gov/29792461/

For related research on collaborative patient care rounds and communication in intensive care, see this study indexed by the National Library of Medicine. The legacy bibliography also identified article S0964339717302148 in Intensive and Critical Care Nursing.

https://pubmed.ncbi.nlm.nih.gov/33262010/

https://pubmed.ncbi.nlm.nih.gov/22875526/

https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html

Talk with Lakeview

Call Lakeview Admissions at (262) 534-8509 to discuss a referral. For clinical records, use the referral fax at (262) 534-8507.

https://www.lakeviewsystem.com/admissions

https://www.lakeviewsystem.com/long-term-acute-care

https://www.lakeviewsystem.com/inpatient-rehabilitation