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Coordination of Care

The following summaries of recent peer-reviewed studies and articles describe the impact of various care coordination activities across a range of care settings on patient experience, patient safety, quality, and outcomes. Citations are linked to full-text articles when available.

Study	Objective	Conclusion
Hincapie, A. L., Slack, M., Malone, D. C., MacKinnon, N. J., & Warholak, T. L. (2016). Relationship between patients' perceptions of care quality and health care errors in 11 countries: A secondary data analysis. *Quality Management in Healthcare, 25*(1), 13-21.	To evaluate the association between **patients' perceived health care quality** and self-reported medical, medication, and laboratory errors in a multinational sample.	▪ Coordination of care is a predictor of self-reported health-related errors. ▪ When patients perceive lapses in communication among their providers and receive conflicting information from multiple health care stakeholders, they are more likely to report medical, medication, and laboratory errors. ▪ Patients can provide valuable insights on received care and play an important role in patient safety initiatives. ▪ Patient engagement initiatives are essential in health care quality management, as they may be the most reliable reporters of some aspects of the health care process.
Alaloul, F., Williams, K., Jones, K. D., & Logsdon, M. C. (2015). Impact of a script-based communication intervention on patient satisfaction with pain management. *Pain Management Nursing, 16*(3), 321-327.	To evaluate the effectiveness of an intervention (**script-based communication, use of white boards, and hourly rounding**) related to pain management on patient satisfaction with nurses' management of pain.	▪ Using script-based communication helps nurses deliver a clear, consistent message that health care providers are aware of patients' needs, caring for their suffering, and working hard to keep them as comfortable as possible. ▪ The intervention improves patients' satisfaction with their pain control and with health care providers' performance in relieving pain. ▪ Clear and consistent communication related to pain can improve patient perceptions of nurses' performance in pain management.
Barata, I., Brown, K. M., Fitzmaurice, L., Griffin, E. S., & Snow, S. K. (2015). Best practices for improving flow and care of pediatric patients in the emergency department. *Pediatrics, 135*(1), e273-e283.	To provide a summary of **best practices for improving flow, reducing waiting times, and improving the quality of care** of pediatric patients in the emergency department.	▪ Several points of impact can reduce emergency department boarding, improve pediatric patient safety, and promote effective, efficient, timely, and patient-centered care, including: – 5-level triage system and nurse-initiated emergency care pathways during initial assessment without delay in seeing a provider – Fast tracking and cohorting of patients – Clinical pathways – Responsive staffing as patients advance through the emergency department system
Carter, J. A., Carr, L. S., Collins, J., Doyle Petrongolo, J., Hall, K.,	To describe how an academic medical center reduced 30-day	▪ A multidisciplinary approach to improving care coordination effectively reduces avoidable readmissions.

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Murray, J., … Tata, L. A. (2015). STAAR: Improving the reliability of care coordination and reducing hospital readmissions in an academic medical centre. *BMJ Innovations, 1*(3), 75-80.	readmissions through improved care coordination using the **STate Action on Avoidable Rehospitalizations (STAAR) program**.	▪ Combining targeted interventions—such as having a discharge Nurse for patient/family coaching and a transitional care pharmacist for predischarge medication reconciliation and postdischarge patient phone calls—with improved hospital coordination augments processes of care for patients during and after admission.
Plonien, C., & Williams, M. (2015). Stepping up teamwork via TeamSTEPPS. *AORN Journal, 101*(4), 465-470.	To provide an overview of the teamwork tool, Team Strategies and Tools to Enhance Performance and Patient Safety (**TeamSTEPPS®**), as it relates to increasing safety and efficiency in the OR setting.	▪ Implementation of TeamSTEPPS in surgical settings results in achieving organizational success factors, thus reducing error and patient harm. ▪ In the perioperative environment, two specific TeamSTEPPS tools—briefings and debriefings—provide the most benefit in improving effective communication among OR team members and improving the actual operations of the department. ▪ Medical team TeamSTEPPS training is associated with decreases in OR start time delays, reduced equipment delays, and fewer reported hand-over issues.
Fox, D., Brittan, M., & Stille, C. (2014). The pediatric inpatient family care conference: A proposed structure toward shared decision-making. *Hospital Pediatrics, 4*(5), 305-310.	To describe a structure for **family care conferences** (FCCs) in the pediatric inpatient setting.	▪ FCCs in the pediatric inpatient setting have the potential to support families in collaborative and shared decision making. ▪ Preparing appropriately for FCCs, using a structured communication style, and engaging parents to express their concerns may improve the outcomes of these meetings.
Hajewski, C. J., & Shirey, M. R. (2014). Care coordination: A model for the acute care hospital setting. *Journal of Nursing Administration, 44*(11), 577-585.	To evaluate a **patient care delivery model** that redefined roles for unit-based nurse case managers and RNs to streamline care coordination processes.	▪ Outcomes within the acute care inpatient setting can be improved by applying a model for care coordination that involves the primary care physician as a partner with a case manager for complex care and a staff RN for predictable care. ▪ A unit-based nurse care coordinator role is essential to facilitate inter-professional care coordination.
Shunk, R., Dulay, M., Chou, C. L., Janson, S., & O'Brien, B. C. (2014). Huddle-coaching: A dynamic intervention for trainees and staff to support team-based care. *Academic Medicine, 89*(2), 244-250.	To evaluate the effectiveness of a **huddle-coaching program** on developing team-based, patient-aligned care in an **outpatient** clinic.	▪ Huddles are the hub of inter-professional, team-based care. ▪ By emphasizing team process and relational factors and actively engaging trainees in leading and facilitating huddles, the huddle-coaching program develops trainees and staff committed to working as a team to deliver quality patient care. ▪ Critical elements of a successful huddle-coaching program include huddle coaches, the huddle checklist, and the team retreat which reinforced basic teamwork and communication skills.
Watkins, L. M., & Patrician,	To evaluate the	▪ The study supports the use of an electronic

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Study	Objective	Conclusion
P. A. (2014). Handoff communication from the emergency department to primary care. *Advanced Emergency Nursing Journal, 36*(1), 44-51.	effectiveness of an electronic handoff **communication** template to notify primary care providers that follow-up care is needed for patients discharged from the **emergency department**.	template for effective handoff communication in the emergency department. ▪ After implementing the Emergency Provider Written Plan of Discharge (eEPWPD) electronic template, there was a 50% increase in the number of patients who received needed diagnostic testing post-discharge. ▪ Post-implementation, there was a 43% improvement in primary care provider follow-up with discharged emergency department patients.
White, B., Carney, P. A., Flynn, J., Marino, M., & Fields, S. (2014). Reducing hospital readmissions through primary care practice transformation. *The Journal of Family Practice, 63*(2), 67-73.	To assess the impact of intensive coordinated **care management and transition processes** on hospital readmissions in a group of **primary care** practices.	▪ Coordinating care through a "culture of continuity" that strengthens outpatient-inpatient caregiver communication improves patient care. ▪ Among patients readmitted, the mean hospital length of stay was lower for patients receiving coordinated care management and transition processes (5.8 days) compared to patients receiving usual care (7.1 days). ▪ Patient readmissions for patients receiving coordinated care management and transition processes decreased significantly from 27% to 7.1%.
Brock, J., Mitchell, J., Irby, K., Stevens, B., Archibald, T., Goroski, A., & Lynn, J. (2013). Association between quality improvement for care transitions in communities and rehospitalizations among Medicare beneficiaries. *The Journal of the American Medical Association, 309*(4), 381-391.	To evaluate whether implementation of improved **care transitions** for patients with Medicare fee-for-service insurance is associated with reduced **inpatient** readmissions and hospitalizations in geographic communities.	▪ Among Medicare beneficiaries in care coordination intervention communities, all-cause 30-day readmissions and all-cause hospitalizations declined. ▪ There was no change in the rate of all-cause 30-day readmissions as a percentage of hospital discharges.
Hansen, L. O., Greenwald, J. L., Budnitz, T., Howell, E., Halasyamani, L., Maynard, G., … Williams, M. V. (2013). Project BOOST: effectiveness of a multihospital effort to reduce rehospitalization. *Journal of Hospital Medicine, 8*(8), 321-427.	To determine the effect of **Project BOOST** (Better Outcomes for Older adults through Safe Transitions) on **inpatient** readmission rates and length of stay.	▪ Hospitals coordinating care through Project BOOST were associated with decreased readmission rates. ▪ No significant change in length of stay was found among the hospitals implementing BOOST tools.
Lee, J. I., Cutugno, C., Pickering, S. P., Press, M. J., Richardson, J. E., Unterbrink, M., … Evans, A.	To develop a descriptive framework illustrating the **interconnected roles** of patients,	▪ Five principle themes influence care transitions: teamwork, systems navigation and management, illness severity and health needs, psychosocial stability, and medications.

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T. (2013). The patient care circle: A descriptive framework for understanding care transitions. *Journal of Hospital Medicine, 8*(11), 619-626.	providers and caregivers in relation to **inpatient** readmissions.	▪ A well-coordinated, collaborative Patient Care Circle (PCC) support system is fundamental to ensuring safe and effective transitions across all settings. ▪ Communication and comprehensive planning between all members of the PCC are instrumental to the circle's ability to address issues pertaining to patient-centered themes.
Kipnis, A., Rhodes, K. V., Burchill, C. N., & Datner, E. (2013). The relationship between patients' perceptions of team effectiveness and their care experience in the emergency department. *The Journal of Emergency Medicine, 45*(5), 731-738.	To examine the relationship between patients' perceptions of **teamwork** and care experience in the **emergency department**.	▪ Patients with positive perceptions of emergency department teamwork were more likely to be satisfied with: – Their overall care experience – Care provided to reduce pain or discomfort – Confidence in the providers ▪ Patients who had positive perceptions of emergency department teamwork were more likely to have a self-reported likelihood to follow treatment recommendations.
Limpahan, L. P., Baier, R. R., Gravenstein, S., Leibmann, O., & Gardner, R. L. (2013). Closing the loop: Best practices for cross-setting communication at ED discharge. *The American Journal of Emergency Medicine, 31*(9), 1297-1301.	To develop **emergency department** best practices for improved **communication** during patient care transitions.	▪ Care coordination best practices establish core expectations for communication with downstream providers. ▪ Identified best practices for emergency department care transitions include: – Obtaining information about patients' outpatient clinicians – Sending summary clinical information to downstream clinicians – Performing modified medication reconciliation – Providing patients with effective education and written discharge instructions
Narayan, M. C. (2013). Using SBAR communications in efforts to prevent patient rehospitalizations. *Home Healthcare Nurse, 31*(9), 504-515.	To explore why communication between physicians and **home health** clinicians can be so problematic and how Situation-Background-Assessment-Recommendation (SBAR) **communication** provides effective and efficient caregiver communication, thereby promoting better patient outcomes.	▪ The SBAR communication method improves not only interprofessional communication, but all communication. ▪ SBAR is very effective when hierarchical positions or critical situations make effective communication difficult. ▪ SBAR communication promotes patient safety and enhances outcomes while controlling health care costs and decreasing hospitalizations. ▪ SBAR can help home health care clinicians with efforts to prevent avoidable hospitalizations.

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Agency for Healthcare Research and Quality (2012). Redesigned inpatient care model increases quality and patient satisfaction, reduces costs and length of stay. Retrieved from: www.innovations.ahrq.gov	To improve efficiency and quality by implementing a **collaborative inpatient care model**.	▪ A collaborative inpatient care model improved patient experience and clinical quality and reduced costs. ▪ Collaborative care: – Reduced cost per case and average length of stay – Improved adherence to clinical best practice standards – Increased nurse productivity – Enhanced patient, staff, and physician satisfaction