# Coordination of Care and the Patient Experience

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.

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| **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, P. A. (2014).** *Handoff communication from the emergency department to primary care*. *Advanced Emergency Nursing Journal*, 36(1), 44-51. To evaluate the 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. | ▪ The study supports the use of an electronic 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. |
▪ 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%. |
▪ There was no change in the rate of all-cause 30-day readmissions as a percentage of hospital discharges. |
### Study | Objective | Conclusion
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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.

To develop a descriptive framework illustrating the interconnected roles of patients, providers and caregivers in relation to inpatient readmissions.  
- Five principle themes influence care transitions: teamwork, systems navigation and management, illness severity and health needs, psychosocial stability, and medications.  
- 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.

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.

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.
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| 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. |
- 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 |
- Total annual Medicare costs for patients participating in the program were 15.7% lower in 2007 ($3240) than for the control group. |
| Robles, L., Slogoff, M., Ladwig-Scott, E., Zank, D., Larson, M. K., & Shoup, M. (2011). The addition of a nurse practitioner to an inpatient surgical team results in improved use of resources, *Surgery*, 150(4), 711–717. | To analyze whether adding a nurse practitioner to a busy inpatient surgery service would improve patient care after discharge. | - Utilizing a nurse practitioner to coordinate care with physicians, strategically implement a discharge plan, and follow up with patients after discharge service led to an overall improvement in the use of resources and a 50% reduction in unnecessary emergency department visits.  
- The reduction in unnecessary emergency department visits saved approximately $800 per patient visit. |