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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.

Study	Objective	Conclusion
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.
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.

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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. T. (2013). The patient care circle: A descriptive framework for understanding care transitions. *Journal of Hospital Medicine, 8*(11), 619-626.	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.
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

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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.
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
Atherly, A., & Thorpe, K. E. (2011). Analysis of the treatment effect of Healthways' Medicare Health Support Phase 1 Pilot on Medicare costs. *Population Health Management, 14*(1), S23–S28.	To evaluate the effect of an **outpatient nurse care coordination program**—the Medicare Health Support Pilot Program—on total Medicare expenditures.	▪ A nurse care coordination program successfully reduced costs among high-cost, chronically ill Medicare patients. ▪ 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.