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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| Alaloul, F., Williams, K., Jones, K. D., & Logsdon, M. C. (in press). Impact of a script-based communication intervention on patient satisfaction with pain management. *Pain Management Nursing.* | 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. |
| 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. |
▪ 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. |
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| 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. |
| 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. |
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- 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 teamwork and 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.                                                                                                               |
- 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 |
| Narayanan, 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 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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- **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 |