Coordination of Care

The following summaries of recent resources and peer-reviewed 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.

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| [*] The Joint Commission (2017). The Joint Commission enterprise content library index. | To inventory links to current Joint Commission content, organized into typical topic areas (e.g., care coordination and transitions) in a searchable PDF. | ▪ Quality, safe patient care depends on caregivers working together across shifts and health care settings.  
▪ Resources listed in the Care Coordination & Transitions section of the index support hand-off communication and coordination of care with periodical articles, videos, and a book—as well as the Transitions of Care portal and a Targeted Solutions Tool (TST®) from the Center for Transforming Healthcare. |
▪ 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 | To provide a summary of best practices for improving flow, reducing waiting times, and improving the quality of care | ▪ 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 |
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| emergency department. *Pediatrics, 135*(1), e273-e283.               | of pediatric patients in the emergency department.                                                                                                                                                        | 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  

| To describe how an academic medical center reduced 30-day readmissions through improved care coordination using the STate Action on Avoidable Rehospitalizations (STAAR) program. | ▪ A multidisciplinary approach to improving care coordination effectively reduces avoidable readmissions.  
▪ 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. |
▪ 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. |
▪ The process allows for both a population-centered and patient-centered approach:  
  1. It addresses the needs of high-risk subpopulations within a larger assigned populations through targeted programs, care plans, or protocols  
  2. It targets a specific aspect of care coordination that will benefit an entire assigned population (e.g., improving primary prevention interventions) |
| Fox, D., Brittan, M., & Stille, C. (2014). The pediatric inpatient family care conference: A proposed structure toward shared | 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  

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| 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. |
| 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%. |
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<td>between quality improvement for care transitions in communities and rehospitalizations among Medicare beneficiaries. The Journal of the American Medical Association, 309(4), 381-391.</td>
<td>with Medicare fee-for-service insurance is associated with reduced inpatient readmissions and hospitalizations in geographic communities.</td>
<td>▪ There was no change in the rate of all-cause 30-day readmissions as a percentage of hospital discharges.</td>
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<td>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.</td>
<td>To determine the effect of Project BOOST (Better Outcomes for Older adults through Safe Transitions) on inpatient readmission rates and length of stay.</td>
<td>▪ Hospitals coordinating care through Project BOOST were associated with decreased readmission rates.</td>
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<td>▪ 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.</td>
<td>▪ No significant change in length of stay was found among the hospitals implementing BOOST tools.</td>
<td>▪ Five principle themes influence care transitions: teamwork, systems navigation and management, illness severity and health needs, psychosocial stability, and medications.</td>
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<td>▪ 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.</td>
<td>To develop a descriptive framework illustrating the interconnected roles of patients, providers and caregivers in relation to inpatient readmissions.</td>
<td>▪ A well-coordinated, collaborative Patient Care Circle (PCC) support system is fundamental to ensuring safe and effective transitions across all settings.</td>
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<td>▪ Kipnis, A., Rhodes, K. V., Burchill, C. N., &amp; Datner, E. (2013). The relationship between patients’ perceptions of teamwork effectiveness and their care experience in the emergency department. The Journal of Emergency Medicine, 45(5), 731-738.</td>
<td>To examine the relationship between patients’ perceptions of teamwork and care experience in the emergency department.</td>
<td>▪ 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.</td>
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<td>▪ Limpahan, L. P., Baier, R. R., Gravenstein, S., Leibmann, O., &amp; Gardner, R. L. (2013). Closing the loop: Best practices for cross-setting communication at ED discharge. The American</td>
<td>To develop emergency department best practices for improved communication during patient care transitions.</td>
<td>▪ Patients who had positive perceptions of emergency department teamwork were more likely to have a self-reported likelihood to follow treatment recommendations.</td>
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| **Journal of Emergency Medicine**, 31(9), 1297-1301. | 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 problematic and how Situation-Background-Assessment-Recommendation (SBAR) communication promotes 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 |