Title: Nursing’s Contributions to Care Coordination and Transitional Care: State of the Science

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Purpose: To synthesize the evidence examining nursing’s contribution to care coordination and transitional care.

Background:
- Nearly half of all Americans suffer from at least one chronic disease.
- People with chronic illness are high utilizers of health care services—representing a disproportionate number of inpatient hospitalizations, home health care visits, prescription medications, and physician visits.
- Health care services for Medicare beneficiaries with five or more chronic conditions account for 75% of total Medicare spending.
- Nearly one in five Medicare discharges result in readmission within 30 days.
- Programs that increase care coordination for the chronically ill through nursing interventions are believed to hold promise for achieving better patient outcomes and lowering costs by reducing use of acute services.
- Twenty-three published randomized controlled trials met review inclusion criteria. This was fewer than expected, given the great amount of interest in these types of interventions in national and state health reform initiatives.

Key Findings:
- The literature that examines the impact of care coordination models on patient outcomes is mixed. The models appear to positively influence some intermediate patient outcomes (adherence), selected clinical indicators, and emotional and social domains of quality of life but not physical domains or mortality rates (there is little evidence of cost-savings achieved through reduction of expensive acute care services).
- The findings in the transitional care literature are more clear—documenting improvements in perceptions of higher quality, improvements in some quality outcomes, and reductions in costs.
- Published findings provide little actionable information to guide model replication with regard to nurse qualifications, roles, or the optimal nurse dose.