Utilizing the AHRQ Care Coordination Atlas as a Framework: An Integrative Review of Transitional Care Models

Daphne Chakurian, BSN, RN, PhD Student and Lori Popejoy, PhD, RN, FAAN

Sinclair School of Nursing
University of Missouri Health

Sinclair School of Nursing
University of Missouri Health

Background and Problem

- 60% of Americans have chronic conditions requiring regular treatment from multiple healthcare providers across multiple settings.
- Opportunities exist to improve the fragmented and expensive U.S. healthcare system through better care coordination
- Transitional care models use care coordination to reduce adverse events and prevent hospital readmissions
- **Purpose of Study: to use the AHRQ Care Coordination Measures Atlas as a framework for analysis of RED and BOOST transitional care model components, implementation factors, and associated patient outcomes.**

Methods

Integrative Literature Review Search Strategy

- PRISMA Reporting Guidelines
- Peer-reviewed and Published between January1, 2015 – August 12, 2020
- Databases searched: PubMed, and Scopus
- Inclusion criteria:
  - Articles on AHRQ Atlas, RED, and BOOST
  - Inpatient, outpatient, and long-term facilities
  - Systematic reviews
- Exclusion criteria:
  - Obstetrical, pediatric, behavioral, or substance abuse populations
  - Opinion/editorials/commentaries
  - Planning of interventions studies

Synthesis of Findings of 14 Studies in 68 Facilities

Are the RED and BOOST Activities Similar to the AHRQ Domains?

AHRQ Care Coordination Activity Domains	Similar RED Activity	Similar BOOST Activity
Establish Accountability/ Negotiate Responsibility		
Communication	X	X
Align Resources with Patient Needs	X	X
Facilitate Transitions	X	X
Assess Needs and Goals		X
Create a Proactive Plan of Care		X
Support Self-management Goals	X	X
Monitor, Follow up, and Respond to Changes	X	X
Linkage to Community Resources		X

- AHRQ CC Atlas provides a theoretical, evidence-based framework for analysis of transitional care models' ability to address core CC functions and prevent hospital readmissions
- Communication was the most common activity in RED and BOOST
- Establish accountability/negotiate responsibility NOT addressed by RED or BOOST
- Model implementation studies identified the lack of leadership support required for culture changes and increased labor costs
- BOOST 8P readmission risk stratification tool may be predictive of readmission
- RED and BOOST have strong evidence of their efficacy at reducing 30-day all-cause preventable rehospitalizations

Conclusions

- This review is the first using the AHRQ CC Atlas as a framework to analyze the RED and BOOST models
- AHRQ CC Atlas was efficacious as a framework for analysis of inpatient care coordination activities confirming previous outpatient/primary care studies findings
- RED and BOOST impact on chronic condition management is limited due to the models focus on hospitalization and the 3-day post discharge period

Implications for Practice and Research

- AHRQ CC Atlas could be used as a framework to think about and track care coordination activities to make decisions
- AHRQ CC Atlas could be used to systematize inpatient nurse care coordination activities and documentation
- This review suggests the need for study of how transitional model components relate to the 30-day readmission rates
- Need for study of gap in establishing accountability/ negotiating responsibility activity

Definitions

AHRQ = Agency for Healthcare Quality and Research;
CC = Care Coordination
RED = ReEngineered Discharge;
BOOST = Better Outcomes by Optimizing Safe Transitions

Acknowledgements

Funding provided by the Charles and Josie Sinclair Fellowship. Many thanks to my advisor, Lori Popejoy, PhD, RN, FAAN, for her encouragement and support and my dissertation Committee: Dr. Vogelsmeier, Dr. Cameron, Dr. Cheak-Zamora, and Dr. Anbari.