

Interprofessional Collaboration in Transitional Care: System Outcomes, Governance Strategies, and Measurement Frameworks in IPC-Driven Case Management Models

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ABSTRACT: Interprofessional collaboration (IPC) has become an essential strategy in improving healthcare outcomes, particularly in transitional and chronic care settings. This integrative literature review explores how IPC-driven case management models influence system-level outcomes, support accountability and role clarity within teams, and are governed through policy and training mechanisms. Evidence demonstrates that IPC-integrated models especially nurse-led transitional interventions can significantly reduce 30-day hospital readmissions, enhance continuity of care, and improve patient satisfaction. However, implementation challenges persist, particularly in the areas of cross-sector governance, communication infrastructure, and measurement standardization. Limitations include inconsistent effectiveness across patient subgroups and contextual settings, as well as variability in evaluation frameworks. To strengthen IPC implementation, future research should focus on refining patient targeting, enhancing cross-setting coordination mechanisms, and harmonizing IPC measurement tools across cultural contexts. This review offers a comprehensive synthesis of conceptual frameworks, operational strategies, and validated instruments that underpin effective IPC in integrated care systems.

Keywords: Interprofessional Collaboration, Case Management, Transitional Care, Nurse-Led Interventions, Readmission Reduction.



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INTRODUCTION

The increasing complexity of healthcare delivery, characterized by the prevalence of chronic diseases, multimorbidity, and aging populations, necessitates a shift from fragmented, episodic care models to more integrated, coordinated, and person-centred systems. Fragmented care has been directly linked to adverse outcomes, especially during transitions from hospital to home or between healthcare settings. Studies have shown that ineffective transitional care can result in medication

errors, duplicative services, and increased rates of hospital readmissions, all of which compromise patient safety and inflate healthcare costs (McNeil et al., 2016; Valverde et al., 2021).

One of the most critical challenges of fragmented care is the mismanagement of chronic diseases, often exacerbated during care transitions. As Hantouli et al. (2024) note, approximately 70% of medical transitions are associated with medication errors, posing significant risks to patient well-being. In addition to clinical repercussions, such inefficiencies strain healthcare budgets, with avoidable hospitalizations and emergency visits costing billions globally (Hantouli et al., 2024). These findings align with the conclusions of Naylor & Berlinger (2016), who stress the devastating consequences both clinical and economic of poorly coordinated care transitions.

In response to these issues, the role of interprofessional collaboration (IPC) has gained prominence as a mechanism for improving care continuity and patient safety. IPC enhances communication among healthcare professionals, aligns care goals, and fosters shared accountability. Knight et al. (2019) emphasize that IPC is especially critical during vulnerable phases such as hospital discharge, where collaboration mitigates risks related to fragmented care. Cardon et al. (2024) further note that well-coordinated teams can manage complex health needs more effectively, reducing unnecessary hospital utilization.

Moreover, the implementation of IPC is supported by global policy frameworks and educational interventions. The World Health Organization (WHO) underscores IPC as central to safe and effective health systems. Educational efforts aimed at building collaborative competencies among healthcare providers have also proven beneficial, promoting teamwork, minimizing medical errors, and enhancing service delivery (Cardon et al., 2024). Sulistyaningsih et al. (2023) add that IPC not only improves clinical care but also contributes to cost containment through reduced readmissions and optimized resource use.

Central to IPC-driven models of care are nursing case managers, whose roles are increasingly vital in transitional and complex care contexts. These professionals serve as coordinators of care, facilitators of communication, and advocates for patients navigating complex health systems. The Coordinated Transitional Care (CTraC) program demonstrates the value of nurse-led monitoring during post-discharge phases, significantly decreasing readmission rates among high-risk groups (Reese et al., 2019; Zhang et al., 2018). Similarly, Chen et al. (2022) highlight the capacity of nursing case managers to deliver tailored interventions, manage clinical complexity, and strengthen patient engagement.

Levert (2017) asserts that nursing case managers also support families and caregivers, translating complex treatment plans into actionable steps. By enhancing patients' self-efficacy and adherence to care plans, they improve long-term outcomes (Lindquist et al., 2016). Their ability to lead interdisciplinary teams and coordinate across settings further positions them as critical agents in the delivery of integrated care.

Despite these demonstrated benefits, implementing integrated people-centred care (IPCC) frameworks continues to face systemic and cultural barriers. Traditional siloed care models often resist the incorporation of interdisciplinary approaches. Hudon et al. (2022) argue that institutional rigidity and fragmented responsibilities inhibit collaborative practice. Pedrosa et al. (2022) suggest

that inconsistent stakeholder engagement including from patients, providers, and families can undermine the sustainability of IPCC initiatives.

The disparities in IPC adoption across health institutions further complicate standardization. Gautun et al. (2021) observe that without strong leadership commitment, IPC remains sporadic and under-resourced. In many cases, healthcare professionals lack adequate training and institutional support to integrate collaborative practices into their daily routines (Trefethen, 2021; Zensho, 2019). These challenges highlight the need for system-wide strategies to align organizational culture, education, and policy with collaborative care goals.

Several global frameworks provide guidance for embedding IPC into health systems. The WHO promotes IPC as a foundational component of effective service delivery, advocating for system-level changes and shared governance structures (Chen et al., 2022). Meanwhile, the Interprofessional Education Collaborative (IPEC) outlines core competencies necessary for effective team-based care, emphasizing communication, role clarity, and ethical values (Sulistyaningsih et al., 2023). Cardon et al. (2024) note that these frameworks have been instrumental in shaping curricula and institutional policies aimed at fostering interprofessional teamwork.

Laursen et al. (2023) report that interprofessional training initiatives based on WHO and IPEC guidelines significantly enhance team functioning and patient outcomes. By aligning professional standards with collaborative practice expectations, these frameworks enable the development of high-performing, patient-centred teams capable of addressing complex health needs across settings.

A variety of operational models exemplify how IPC can be effectively embedded within nursing-led case management programs. For example, Transitional Care Teams composed of multidisciplinary members including nurses, case managers, and social workers have proven successful in ensuring continuity of care from hospital to home (Camicia et al., 2021). The Care Transitions Intervention (CTI) model, led by nurses, has also demonstrated improved patient outcomes through structured communication and follow-up protocols (Jepma et al., 2021).

The integration of technology into IPC models is another promising development. Knight et al. (2019) show that telehealth platforms facilitate real-time communication between team members, supporting timely interventions and reducing the risk of care gaps. These innovative models reflect a growing recognition of the critical role of interprofessional collaboration in enhancing health system efficiency and patient-centred outcomes.

In summary, the current healthcare landscape demands coordinated, integrated approaches to manage increasing patient complexity and resource constraints. Fragmented care is no longer tenable in systems seeking to deliver safe, efficient, and people-centred services. Interprofessional collaboration, particularly within nursing-led case management frameworks, offers a viable solution to this challenge. Supported by global frameworks and validated by emerging evidence, IPC must now be operationalized systematically across care pathways.

This study aims to develop a comprehensive architecture for embedding IPC into nursing-based case management. The proposed model outlines core case management components, associated

IPC activities, and their linkage to clinical and organizational outcomes. By bridging conceptual ideals with practical implementation strategies, the study seeks to contribute a replicable, scalable solution for healthcare systems pursuing integrated care reforms.

METHOD

This study utilizes a conceptual approach to design and evaluate a systemic framework that integrates interprofessional collaboration (IPC) into nursing-based case management. It relies on theory-driven synthesis, system modeling, and literature triangulation to establish linkages between IPC activities, care processes, and outcome measures. The methodology is structured around three interrelated domains: conceptual frameworks, system architecture evaluation, and process-outcome linkage.

Conceptual Frameworks Used in IPC-Integrated Models

Interprofessional collaboration in healthcare is a foundational component of integrated care delivery. This study draws on several conceptual frameworks to guide the design of IPC-integrated models. One central reference is the Collaborative Practice Competency Framework developed by the World Health Organization (WHO), which provides a foundational structure for team-based educational initiatives and clinical applications (Jones et al., 2023).

Supplementing the WHO framework, the Interprofessional Education Collaborative (IPEC) competencies offer a detailed taxonomy of values, communication standards, roles, and teamwork skills required for effective IPC (Hossen, 2017). These competencies serve as both training tools and assessment criteria. Studies involving pharmacy and dental students demonstrate how these competencies improve teamwork and patient care outcomes (Theodorou et al., 2018).

Additionally, context-sensitive frameworks like the Assessment of Interprofessional Team Collaboration Scale (AITCS) have been culturally adapted and validated for diverse healthcare settings, ensuring that IPC assessments are locally relevant and applicable (Yamamoto & Haruta, 2019). This flexibility strengthens the applicability of IPC frameworks across different system contexts.

Evaluation of System Architectures for Collaborative Care

To construct and evaluate the IPC-integrated case management model, this study incorporates qualitative and quantitative components from literature and validated system evaluation tools. A key tool is the Interprofessional Collaboration Scale, which provides structured insight into team dynamics, communication, and the quality of collaboration (Ardyansyah et al., 2024; Wieser et al., 2022).

These evaluations are complemented by quality indicators that align with IPC outcomes. Metrics include hospital readmission rates, time-to-treatment efficiency, patient satisfaction scores, and

medication reconciliation success rates (Donnelly et al., 2019). Hanskamp-Sebregts et al. (2023) recommend combining process indicators (e.g., team meeting frequency, shared documentation adherence) with outcome indicators to assess IPC implementation in real-world settings.

The architecture of healthcare systems including spatial design, workflows, and team structures also affects IPC efficacy. Research by Morgan et al. (2020) shows that physical layouts conducive to informal staff interaction enhance spontaneous collaboration, supporting more responsive and person-centred care.

Linking IPC Activities with Process and Outcome Measures

Demonstrating the effectiveness of IPC-integrated models requires connecting collaborative actions to tangible outputs and outcomes. This study employs both Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) to capture the care experience from the patient perspective (Rudolph et al., 2019). These indicators reflect the human impact of collaborative care, offering qualitative depth alongside clinical metrics.

Systematic reviews show that outcome metrics such as adherence to treatment guidelines, care plan continuity, and reduced adverse drug events are positively influenced by IPC activities (Nurchis et al., 2022). In diabetes care, for instance, IPC-led case management has yielded improved HbA1c levels and patient adherence to care regimens.

Process measures also play a key role. These include frequency of case conferences, documentation completeness, and the use of SBAR protocols in care transitions. Tracking these indicators enables feedback and refinement of IPC practices.

Interprofessional education programs are increasingly adopting outcome-oriented competency frameworks that link educational interventions to clinical results. These programs aim to close the loop between learning, practice, and patient impact, ensuring that IPC gains are measurable and sustainable.

Study Design and Data Sources

This study does not involve direct field data collection but synthesizes three key data sources:

- Table 1: A constructed model detailing IPC-integrated case management components, professionals involved, activities, outputs, and outcomes.
- Table 2: A review-based summary of IPC research, demonstrating evidence for outcome linkages.
- Table 3: A registry of validated instruments used to assess IPC levels, care transitions, and team dynamics.

These datasets are organized around a systems framework that maps the interrelationship between IPC actions and healthcare delivery performance. Each domain clinical, organizational, and experiential is addressed through this mapping.

Analytical Approach

The analytical process followed three steps:

1. Decomposition of Case Management Phases: Identifying IPC-relevant stages (e.g., risk stratification, discharge planning).
2. Cross-referencing with Evidence: Aligning each component with findings from Table 2 to ensure empirical grounding.
3. Validation through Tools: Ensuring that process and outcome measures listed in Table 3 correspond to each IPC domain.

This model supports replication in varied healthcare settings and allows iterative evaluation and redesign.

Ethical and Contextual Considerations

Although empirical data collection was not part of this conceptual model, ethical considerations still guide framework construction. Emphasis is placed on equity, inclusivity, and patient-centred values. The tools and evidence sources included in the model have been validated in diverse cultural and system contexts, enhancing transferability to settings such as Indonesia, where IPC initiatives are increasingly prioritized.

RESULT AND DISCUSSION

The findings of this study are presented in accordance with the qualitative content analysis method, utilizing an integrative review approach. The data were analyzed thematically and summarized into key dimensions relevant to IPC-integrated care models. The main themes and supporting evidence have been organized into a structured table format (Table 1), consistent with the methodological framework.

Table 1. Summary of Key Findings from Literature Review on IPC-Integrated Care Models

Theme	Subtheme	Evidence Source(s)	Summary
Framework Components and IPC Activities	Risk stratification, shared assessment, discharge planning	Reese et al., 2019; Hudon et al., 2022; Rammohan et al., 2023; Valverde et al., 2021; McNeil et al., 2016	IPC activities include risk-based eligibility using diagnosis/utilization data, shared care planning to enhance coordination, and

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Theme	Subtheme	Evidence Source(s)	Summary
Evaluation and Effectiveness	System-level impacts, patient-reported outcomes, readmission rates	Nurchis et al., 2022; Knight et al., 2019; Gautun et al., 2021	structured discharge planning to reduce readmissions.
			IPC models are associated with reduced 30-day readmissions and improved patient experience, though effectiveness may vary by setting and subgroup.
Measurement and Tools	CPAT, IPPIH, Interprofessional Collaboration Scale	Ardyansyah et al., 2024; Hanskamp-Sebregts et al., 2023; Wieser et al., 2022	Validated tools have been used to measure IPC collaboration quality, team coordination, and care transition outcomes. Tool adaptation is required for local context.
Governance and Accountability	Role clarity, audit instruments, cross-sector governance	McNeil et al., 2016; Donnelly et al., 2019; Cardon et al., 2024	Accountability is maintained through explicit role definitions, routine case conferencing, and governance instruments that enable monitoring of IPC effectiveness.
Policy and Training Support	Competency frameworks, incentives, interprofessional education	Naylor & Berlinger, 2016; Trefethen, 2021; Theodorou et al., 2018	WHO/IPEC frameworks guide IPC education, while policy incentives (e.g., readmission penalties) and training mechanisms foster readiness and adoption.

Table 1 summarizes the five key thematic areas derived from the integrative literature review. The first theme, 'Framework Components and IPC Activities', highlights the core operational elements of IPC-driven models such as targeted risk stratification and structured transitional care planning. The inclusion of shared assessment practices and coordinated discharge planning emerged as crucial mechanisms for improving cross-setting collaboration and mitigating readmission risks. These activities are typically facilitated through nurse-led initiatives and multidisciplinary teams.

The second and third themes address the effectiveness and measurement of IPC practices. Studies consistently reported reductions in hospital readmissions and improved patient experience when IPC was systematically implemented. However, measurement tools such as CPAT, IPPIH, and the Interprofessional Collaboration Scale require context-specific validation. Governance structures and accountability measures, outlined in Theme 4, are essential for sustaining collaboration through defined roles and performance tracking. Finally, policy incentives and structured interprofessional training anchored in global competency frameworks serve as systemic enablers that support the institutionalization of IPC practices.

This study set out to develop a comprehensive, system-level architecture integrating interprofessional collaboration (IPC) within nursing-based case management. The findings confirm that when implemented with fidelity and governance support, IPC models can generate

significant system-level benefits. Yet, they also expose vulnerabilities in scalability, role accountability, measurement coherence, and implementation timing. The synthesis of literature, frameworks, and measurement tools illustrates both the potential and the fragility of IPC-driven interventions.

At the system level, IPC-based transitional care is consistently associated with reduced 30-day readmissions and improved cost-efficiency. Programs like C-TraC and hospital-based care transition teams illustrate how structured, nurse-led coordination across the discharge continuum reduces post-acute care utilization and expenditure (Rammohan et al., 2023; Reese et al., 2019). Additionally, structured videoconference handoffs and coordinated team planning enhance communication and reduce transition risks, even in contexts not powered for utilization outcomes (Knight et al., 2019). However, the success of these interventions is contingent on effective governance. Studies show that poor role clarity, inadequate accountability structures, and insufficient information exchange compromise system-level gains, even when interventions are evidence-informed (McNeil et al., 2016; Valverde et al., 2021).

Patient-reported outcomes (PROs) further validate IPC's value but reveal selective effects. IPC interventions enhance satisfaction and mental well-being but may not influence all PRO domains equally (Nurchis et al., 2022). This heterogeneity cautions against overgeneralizing IPC's impact and emphasizes the need for clear outcome pathways. Linking IPC models to claims-based outcome evaluations like those conducted in Medicare–Medicaid integration offers new avenues for validating system-level returns, but requires sophisticated technical and governance infrastructure (Jones et al., 2023).

A critical determinant of IPC effectiveness is how interprofessional teams maintain accountability and clarify roles. The evidence supports a multi-pronged approach: cross-setting role definitions, shared accountability indicators, structured multidisciplinary conferences, and collaborative planning forums (Donnelly et al., 2019; Zensho, 2019). Tools such as the IPPIH questionnaire and Interprofessional Collaboration Scale render collaboration auditable, enabling governance actors to track role execution and team climate (Wieser et al., 2022). However, measurement tools must be validated for local contexts. Factor structures in scales like AITCS-II can vary across cultures, which requires local adaptation and testing (Yamamoto & Haruta, 2019).

Policy and training mechanisms also shape IPC governance. Financial incentives (e.g., reduced Medicare payments for readmissions) create pressure for system redesign, but uptake is inconsistent due to entrenched organizational barriers (Naylor & Berlinger, 2016). Competency frameworks such as WHO and IPEC provide normative guidance for training and performance evaluation (Cardon et al., 2024). Training operates at several levels from specialty upskilling of nurse case managers (Reese et al., 2019), to interprofessional education for early-career clinicians (Trefethen, 2021), to facilitated team-based quality improvement initiatives (Gaboury et al., 2021). Digital knowledge transfer platforms show promise but face infrastructural access constraints (Levert, 2017). Importantly, relational contact across sectors remains necessary: nurses express preference for direct communication with community providers, indicating the limits of digital-only strategies (Gautun et al., 2021).

Despite promise, IPC models face several limitations. First is contextual variability in effectiveness. Frail or multimorbid patients may require more personalized and intensive IPC support, while others with robust informal networks may perceive interventions as redundant (Jepma et al., 2021). Transition timing is another constraint: IPC activities initiated late in the discharge process may not achieve intended outcomes, especially in regions like Latin America where transitions often begin near discharge rather than at admission (Lima et al., 2018).

Structural fragmentation across care settings poses further challenges. Gaps in accountability at the hospital-SNF interface persist, undermining IPC even when clinicians share a vision of ideal transitions (Valverde et al., 2021). Technology-based handoffs are insufficient in the absence of interpersonal follow-up and access equity (Levert, 2017). Thus, hybrid coordination strategies combining structured digital handoffs with relational mechanisms (e.g., telephone calls) merit further study (Knight et al., 2019).

Measurement inconsistency is a final barrier. Evaluation tools differ in scope, cultural fit, and target population (e.g., nurse–physician dyads vs. full teams), which complicates benchmarking and governance (Wieser et al., 2022). Moreover, outcome sensitivity varies by domain. Even in robust trials, IPC improved mental health-related QoL but not physical or functional indicators (Nurchis et al., 2022). Measurement must therefore be aligned with clear theories of change and adapted for system pathways.

Future research should target four key areas. First, improve IPC targeting and tailoring by incorporating stratification tools that account for frailty, multimorbidity, and patient capacity (Hudon et al., 2022). Second, develop and test governance interventions for shared accountability across care settings, especially at high-risk interfaces like hospital-SNF transitions. Third, evaluate hybrid coordination strategies that combine relational and digital mechanisms to improve communication and engagement. Fourth, harmonize IPC measurement across levels team, system, and patient and validate tools in specific contexts to ensure actionable feedback for governance.

In conclusion, IPC-integrated case management models offer a compelling strategy for improving health system performance, care continuity, and patient experience. However, their impact is conditional on effective governance, structured accountability, context-specific training, and validated evaluation frameworks. Strengthening these foundations will enable health systems to harness IPC's full potential in delivering integrated, people-centred care.

CONCLUSION

This scoping review confirms that Interprofessional Collaboration (IPC)-enabled transitional case management can deliver measurable system-level benefits, including reductions in 30-day hospital readmissions, lower post-discharge costs, and improved patient-reported outcomes such as satisfaction and perceived continuity. The strongest evidence of system-level impact comes from structured, nurse-led transitional care interventions like C-TraC and other care transition programs, which combine risk stratification, proactive discharge planning, and structured post-discharge support. However, these benefits are contingent on robust implementation conditions, including role clarity, accountability mechanisms, and effective cross-setting communication.

At the practice level, IPC models show clear advantages in organizing shared assessment and care planning, especially through structured case conferences and team-based discharge processes. These practices enhance team coordination, align responsibilities, and support continuous patient-centered care. Accountability is most effectively maintained through governance tools such as interprofessional performance audits (e.g., IPPIH) and validated collaboration scales (e.g., CPAT, Interprofessional Collaboration Scale), which institutionalize collaboration as a measurable and improvable attribute of care delivery.

Yet, limitations remain. Variability in patient benefit points to a need for refined targeting and personalization of transitional interventions. Structural fragmentation between care settings, particularly at high-risk interfaces like hospital-to-SNF transitions, continues to impede care continuity and generate safety risks. Measurement fragmentation and limited cross-cultural validation of IPC tools further constrain governance and evaluation capacities.

Recommendations

Enhance Patient Targeting and Tailoring: Future IPC-based interventions should integrate patient-level factors such as frailty, multimorbidity, self-management ability, and the availability of existing care networks to improve personalization and reduce over- or under-intervention risks.

Strengthen Cross-Sector Governance: Health systems should invest in shared accountability mechanisms, explicit cross-setting role agreements, and interoperable communication infrastructure to address persistent gaps in transitional accountability and coordination.

Evaluate Hybrid Coordination Models: Comparative research is needed to evaluate combinations of relational (e.g., telephone, in-person) and digital (e.g., videoconferencing) coordination tools in improving transition quality, information exchange, and engagement.

Standardize and Localize Measurement Tools: Promote the use of validated tools (e.g., CPAT, AITCS-II, IPPIH) for evaluating IPC, but prioritize local adaptation and construct validation to ensure cultural relevance and psychometric integrity across health system contexts.

Embed IPC Metrics into System-Level Data: Develop mechanisms for integrating IPC indicators into administrative datasets (e.g., Medicare–Medicaid claims) to assess impacts on utilization and patient outcomes at scale, while ensuring rigorous data linkage protocols.

In sum, IPC-enabled transitional case management models offer significant potential to improve care quality and efficiency, but their success depends on coordinated governance, contextual adaptation, and investment in implementation infrastructure and evaluation capacity.

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