

Implementing Interprofessional Collaboration in Transitional Care: A Review of Evidence and Policy Implications

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ABSTRACT: Interprofessional collaboration (IPC) is essential for quality transitional care, yet systemic, cultural, and operational barriers hinder its implementation. Embedding IPC into health system infrastructure is critical for sustainability and improved outcomes, particularly during hospital-to-community transitions. This review synthesized qualitative, quantitative, and mixed-method evidence on IPC implementation in transitional care, organizing findings thematically to identify best practices, barriers, and implementation strategies, aligned with the WHO IPCHS and IPEC frameworks. Evidence indicates that IPC sustainability requires institutionalization through standardized pathways, team competency frameworks, and digital coordination tools. Collective and distributed leadership plays a central role in overcoming professional silos and driving cultural transformation. Feedback mechanisms—such as Plan–Do–Study–Act (PDSA) cycles, validated transition measures (e.g., CTM-15), and event classification tools—support continuous learning and adaptation. Interprofessional education (IPE), when aligned with practice expectations and backed by leadership, strengthens workforce readiness. International comparisons show that while IPC principles are transferable, successful implementation depends on contextual adaptation and culturally sensitive measurement systems. Embedding IPC in policy and institutional practice requires cross-sector collaboration, strategic workforce investment, and robust monitoring. Policymakers should mandate IPC competencies in professional training, support feedback-driven implementation, and fund interoperable digital infrastructure, with local adaptation and system-level leadership essential for scaling IPC sustainably.

Keywords: Interprofessional Collaboration, Transitional Care, Healthcare Teams, Sustainability, Leadership.



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INTRODUCTION

Transitions of care such as those from hospital to home or to post-acute settings are increasingly recognized as critical junctures in healthcare delivery that profoundly influence outcomes for patients, caregivers, and health systems. These transitions are frequently compromised by

discontinuities, miscommunication, and organizational fragmentation. In response, interprofessional collaboration (IPC) has emerged as a globally endorsed solution to ensure coordinated, person-centered care across settings. Frameworks such as the World Health Organization's Integrated People-Centred Health Services (IPCHS) and interprofessional education models like IPEC have promoted IPC as foundational to improving healthcare integration. Despite these imperatives, translating IPC into consistent, measurable improvements in transitional care remains challenging, particularly in hospital environments.

Within the growing body of transitional care research, IPC is not always formally defined but is rather inferred through practices described as interdisciplinary, multidisciplinary, or collaborative. The literature operationalizes IPC as encompassing three core functions: the coordination and continuity of care across transitions (e.g., hospital-to-home or hospital-to-hospice), structured information exchange during handoffs or discharge, and shared care planning across professional roles, often including patients and caregivers (Abu et al., 2018; Werner et al., 2016). These elements are not just idealized concepts but are treated as functional safeguards against transition failures, such as lapses in information transfer or unclear task ownership, that have long plagued patient journeys between care environments (Izumi et al., 2020).

Empirical evidence in transitional care literature identifies three core IPC competencies as central to improving outcomes. First, communication and information transfer are consistently reported as essential IPC skills. Studies highlight that breakdowns in discharge communication are a leading cause of adverse events, and interventions like standardized discharge rounds have been shown to improve outcomes (Bumpas & Copeland, 2021; Ozaki et al., 2023). Second, the literature underscores the importance of role clarity, coordination, and accountability across professional boundaries. Numerous studies show that uncertainty about "who is in charge" after discharge undermines team efficiency and patient confidence (Davidson et al., 2017; Shirley et al., 2018). Third, patient and family involvement in transitional work is increasingly recognized as both a competency and outcome of IPC. Research in palliative and chronic care transitions has emphasized the necessity of relational continuity, education, and the preparedness of caregivers as key success metrics (Chartrand et al., 2023; Saunders et al., 2021).

IPC contributes to improved transitional outcomes through several evidence-based pathways. Structured communication and shared planning increase the reliability of discharge processes, enhance clarity for patients, and mitigate information discontinuity. Patient experience data further confirms that multidisciplinary discharge planning improves satisfaction, preparedness, and understanding of follow-up plans (Jesus et al., 2024; Leithaus et al., 2023). In addition to subjective improvements, IPC is associated with reductions in 30-day readmissions and emergency visits. Transitional care models that integrate interdisciplinary coordination before and after discharge report significantly better clinical and patient-reported outcomes across populations ranging from stroke to skilled nursing facility (SNF)-to-home transitions (Saragih et al., 2023; Toles et al., 2023).

Medication-related safety risks are another domain where IPC shows strong impact. Transitions are well-documented periods of vulnerability for medication errors. Studies involving pharmacists as integrated team members demonstrate reductions in readmissions and improved reconciliation processes, suggesting that IPC directly enhances medication safety (Hovey et al., 2023; Shaver et

al., 2019). Across studies, IPC is therefore positioned not merely as a set of values or abstract competencies, but as an intervention that improves safety, efficiency, and patient experience by fostering process reliability and relational continuity.

Despite the strong rationale and growing evidence base, IPC implementation remains uneven across hospitals. Barriers are multifactorial. Communication fragmentation and information discontinuity persist, particularly in handoffs and discharges. Structural ambiguities related to team roles and accountability hinder coordination, as shown in both clinician and caregiver perspectives (Abu et al., 2018; Shirley et al., 2018). Complexity across settings including variations in hospital, SNF, and home-care infrastructure makes IPC difficult to standardize. Studies also identify language and cultural barriers that affect team processes and patient engagement, particularly in diverse or underserved populations (Sandoval et al., 2024). Moreover, operational pressures such as staffing constraints and crisis conditions (e.g., COVID-19) further disrupt IPC routines and necessitate adaptive strategies (Chovanec & Howard, 2021).

The WHO IPCHS framework, while not directly analyzed in the core reference set, advocates for care models that align closely with IPC principles namely, continuity, integration, and responsiveness to patient/caregiver experience. Although this study does not rely on IPCHS directly, its principles echo in the recurring themes of IPC effectiveness found across the literature.

Similarly, while IPEC's formal competencies are not cited in the reviewed evidence, transitional care quality goals reflected in the studies such as improved patient experience, reduced adverse events, and enhanced follow-up closely map to IPEC domains like communication, roles/responsibilities, and teamwork. Structured interdisciplinary planning, early inclusion of all stakeholders, and coordinated follow-up are key IPC mechanisms seen to influence outcomes (Smith et al., 2024; Thaker et al., 2022).

Recent literature has further consolidated IPC's association with meaningful patient outcomes. Studies show that structured team-based transitional interventions improve patient satisfaction and reduce acute care reuse. Interdisciplinary discharge planning, pharmacist integration, and care pathway standardization are prominent strategies linked to better patient experience and readmission reduction (Bumpas & Copeland, 2021; Kinard et al., 2023).

In sum, IPC is a multifaceted mechanism that enhances transitional care through clear communication, defined responsibilities, and collaborative care planning. Yet, its implementation faces systemic, operational, and contextual barriers. By synthesizing empirical evidence on IPC competencies, impact mechanisms, and challenges, this study seeks to provide a strategic framework for bridging implementation gaps in IPC practice. This framework will be grounded in domain-specific barriers and facilitators identified in recent literature and offer targeted strategies aligned with global priorities for integrated, people-centered care.

METHOD

This chapter outlines the methodological approach employed to investigate interprofessional collaboration (IPC) implementation barriers and facilitators in transitional care. The methodology

is structured around three key areas: (1) qualitative designs suitable for IPC evaluation, (2) framework analysis techniques for IPC mapping, and (3) validated tools and data sources for assessing IPC and transition outcomes.

Qualitative Designs for Evaluating IPC Implementation Barriers

1. Qualitative Descriptive Design

Semi-structured interviews are extensively supported in the literature as a practical method for identifying implementation challenges in transition contexts. These interviews have been used to explore themes such as communication lapses, caregiver roles, and coordination breakdowns across hospitals and post-acute settings (Abu et al., 2018).

2. Focus Groups and Multi-Stakeholder Analyses

Focus groups allow exploration of role-specific experiences and complexities in IPC. Multi-perspective qualitative analysis is especially relevant when the implementation problem spans professions and settings (Kurniasih et al., 2022).

3. Phenomenology

Phenomenological approaches are appropriate when analyzing the lived experience of IPC under high-pressure conditions (e.g., ICU resuscitations). This method captures relational and experiential barriers in acute care IPC environments (Lin et al., 2021).

4. Qualitative Content Analysis

Both inductive and directed content analysis are suited for categorizing IPC barriers and mapping participant insights to structured domains (Keshmiri, 2022). Directed approaches support comparison with existing implementation frameworks.

5. Grounded Theory

Although only protocol-level evidence is available, grounded theory is positioned as an appropriate design for generating explanatory models of IPC implementation (Num et al., 2023).

6. Mixed Methods

Mixed methods designs are used when linking qualitative barriers to measurable outcomes is necessary. This approach has been applied in palliative transitions, pandemic response, and interprofessional education.

Framework Analysis for IPC Mapping

Justification for Domain-Based Mapping

IPC in transitional care involves multiple failure points (e.g., medication, discharge planning), requiring structured mapping across domains to detect patterns in implementation success or failure.

Framework Analysis Techniques

Framework-based methods used in the dataset include hybrid deductive–inductive coding, directed content analysis, and matrix-based theme organization.

Practical Mapping Procedure

The literature supports the following analytic process:

- Define an a priori framework (e.g., NQF ED Transitions, IPC competencies)
- Apply hybrid coding (framework-aligned and emergent themes)
- Use matrices stratified by role, setting, or phase
- Synthesize findings into actionable targets (e.g., handoff protocols, caregiver engagement)

Role of Framework Analysis in Mixed Outcome Settings

Framework mapping is particularly useful when implementation fidelity is variable, helping differentiate intervention design from contextual or delivery barriers.

Validated Instruments and Data Sources for IPC Evaluation

Distinction Between IPC and Transition Measures

Tools such as CTM-15 assess patient-perceived transition quality, while instruments like AITCS-II and IPEC tools directly measure IPC team competencies or self-efficacy.

Care Transitions Measure (CTM-15)

Validated for use in multiple countries and shown to predict medication safety and discharge quality (Marsall et al., 2024). Best used as an outcome indicator sensitive to IPC effects, though not a direct team measure.

Other Transition Quality Instruments

The PACT-M instrument was applied in chronic disease transitions but lacks validation details in the provided sources.

IPC-Specific Instruments

- AITCS-II: Measures interprofessional collaboration, used in primary care settings.
- IPEC Competency Tool: Self-assessment used in discharge education simulation.
- ICCAS: Applied in OSCE-based interprofessional assessments.
- IPL Assessment Tool: Developed and validated for continuing education.

CPAT – Evidence Gap

While CPAT is commonly cited in IPC evaluations, the dataset does not contain references supporting its validation. Thus, it cannot be formally supported within this study.

RESULT AND DISCUSSION

Structure & Role Clarity

Frameworks Defining Interprofessional Roles

The literature demonstrates that both formal frameworks and experiential insights contribute to interprofessional role definition. Hospital-based and person-centered care frameworks (McLaney et al., 2022) codify competencies and behaviors expected of interprofessional teams, offering structured role clarity for IPC in practice and education. Qualitative studies emphasize role boundaries and accountability gaps as recurrent themes in ICU resuscitations and transitional care, revealing how professionals and caregivers navigate unclear or contested responsibilities in high-pressure or cross-setting scenarios (Abu et al., 2018).

Effectiveness of SOPs and Role Matrices

Though controlled evidence is lacking, SOPs and standardization mechanisms are consistently cited as practical strategies to clarify roles in IPC contexts. In cancer care and heart failure pathways, SOPs, clear job descriptions, and structured discharge planning were used to reduce confusion and improve collaboration (Thaker et al., 2022). These interventions suggest SOPs function as boundary-defining tools, even though their direct effects on IPC clarity were not isolated.

Role Clarity and Outcomes

Several structured models link improved outcomes with role clarity mechanisms. Standardized discharge rounds, interdisciplinary care pathways, and cross-setting collaboratives support the view that clarifying roles enhances patient satisfaction, medication reconciliation, and care planning quality (Davidson et al., 2017). However, many evaluations treat role clarity as an assumed

mechanism rather than a tested mediator, pointing to a measurement gap in IPC implementation science (Brown et al., 2024).

Professional Hierarchy

Hierarchical cultures and professional silos are widely described as barriers to IPC. Paternalism, seniority, and uni-professional centrism disrupt shared accountability, while collective leadership and team-centered accountability are cited as enabling conditions (Hosseinpour & Keshmiri, 2024). In transitional care, hierarchy manifests through uncertainty about who is responsible, especially across settings, placing coordination burdens on patients and caregivers.

Communication

SBAR and Handoff Communication

No evidence regarding SBAR's effectiveness is available in the dataset. However, provider miscommunication, information overload, and untimely discharge documentation are consistently identified as transition-related barriers, justifying structured communication tools even if not explicitly studied here (Abu et al., 2018).

Case Conferences

Routine team-based discussions such as case conferences are supported by evidence from interdisciplinary videoconference models (ECHO-CT), standardized rounds, and collaborative stakeholder forums. These structures enable shared identification of transitional care events and intervention targets, improving coordination across hospital and post-acute settings (Bumpas & Copeland, 2021).

Communication Errors in Transitions

Communication-related errors are among the most prevalent problems in transitional care. Misaligned discharge information, inaccurate handoff content, and unclear instructions for caregivers contribute to poor outcomes across home, SNF, and hospice settings (Saunders et al., 2021). These failures underscore the need for IPC-sensitive communication infrastructure.

Training and Communication Effectiveness

Interprofessional training programs consistently show improvements in self-efficacy and collaborative communication. Educational simulations, OSCEs, and structured assessment tools (e.g., ICCAS, IPEC) strengthen IPC competencies, though changes are primarily seen in attitudes and skills rather than utilization outcomes (Smith et al., 2024).

Domain 3: Data Systems

EHR Interoperability Barriers

Direct evidence of EHR interoperability challenges is sparse, but studies document that home care settings often lack shared documentation tools, forcing reliance on inconsistent communication channels (Sekanina et al., 2024). Similarly, discharge information delays and medication reconciliation issues reflect gaps in cross-setting data systems.

Care Plan Templates

Structured care plans are highlighted as improvement targets in transitional care collaboratives, but no study measures the effects of shared care plan templates on documentation quality (Thaker et al., 2022).

Audit Tools for IPC Documentation

No audit tools focused on IPC documentation are present. However, CTM measures and transitional care event classifications indirectly capture communication failures and documentation deficits.

Digital Innovations

Digital models such as ECHO-CT videoconferencing and virtual discharge planning simulations support IPC by facilitating structured communication and skill-building. During the COVID-19 pandemic, remote care models were adopted to maintain transitional care coordination (Chovanec & Howard, 2021).

Domain 4: Human Resources

Workload as Barrier

High workload and limited availability are repeatedly identified as IPC barriers, particularly in home care and hospital settings. Competing demands, dual roles, and inadequate compensation reduce capacity for collaborative engagement.

Caseload Ratios

No caseload benchmarks for nurse case managers are reported. While their role in transitions is emphasized, quantitative guidance is not provided.

Risk-Based Triage

Although interventions often target high-risk populations, no study explicitly evaluates risk-based triage algorithms for coordination. The inference is that complexity-informed targeting is used, but triage models are not tested (Chartrand et al., 2023).

Workforce Sustainability Strategies

Sustainable IPC is supported through competency frameworks, training pipelines, and continuous improvement cycles. Structured development programs and standardized pathways align team roles and build IPC capacity across systems (Ong et al., 2019; Weerdt et al., 2024)

Domain 5: Organizational Culture

Leadership

Leadership behaviors are central to IPC success. Collective leadership during emergencies and broad stakeholder engagement in framework development are cited as facilitators, while leadership gaps are described as barriers (Kurniasih et al., 2022).

Incentives

The dataset lacks studies on financial or policy incentives for IPC. One study identified compensation as a barrier, suggesting an indirect influence of incentive structures.

Training and IPC Culture

Interprofessional training builds collaboration culture by enhancing role understanding, communication, and mutual respect. However, structural cultural issues like hierarchy and limited IPE exposure require upstream reforms (Hollaar et al., 2023)

Organizational Commitment

Framework development, collaborative partnerships, and continuous improvement initiatives demonstrate organizational commitment to IPC sustainability (McLaney et al., 2022)

Domain 6: Evaluation

CTM-15 and CPAT

CTM-15 is validated and widely used to assess patient-reported transition quality, though not IPC per se (Flink et al., 2018). CPAT is not represented in the dataset.

Outcome Indicators

Commonly monitored outcomes include readmissions, safety incidents, preparedness, and satisfaction. CTM-15 and event classification tools are used to link transition quality with safety and health outcomes.

Dashboards

While dashboards are not directly evaluated, metric-based collaboratives (e.g., INFORM) and structured event reviews support dashboard-like processes for monitoring and improving IPC transitions.

Feedback Mechanisms

Feedback processes such as Plan–Do–Study–Act cycles, stakeholder consultations, and OSCE assessments enhance IPC evaluation and adaptation (Maerten-Rivera, 2019).

IPC Sustainability, Long-Term Impacts, Leadership/Feedback Mechanisms, and International Best Practices

System-Level Interventions and Their Influence on IPC Sustainability and Scalability

Sustainable interprofessional collaboration (IPC) hinges on systemic integration, where collaboration is embedded into institutional infrastructure rather than limited to individual initiative or pilot programs. The literature consistently emphasizes that IPC becomes scalable and resilient when supported by standardized workflows, shared team competencies, and learning systems that promote consistency across roles and settings (McLaney et al., 2022; Thaker et al., 2022). From a human factors perspective, interventions that address the system-level complexity of care transitions rather than isolated behavioral change are more likely to achieve durability and transferability (Werner et al., 2016).

Frameworks supporting team-level and interprofessional competencies play a critical role in scalability. McLaney et al. (2022) propose a hospital-based framework designed for universal adoption within institutions, incorporating patient and stakeholder input to align behaviors across teams. Complementary to this, the INPRO framework (Weerdt et al., 2024) supports lifelong interprofessional development and can travel across national and linguistic boundaries. This dual-level approach standardizing expectations within organizations and across educational-practice continuums enables broader implementation beyond localized contexts (Duijn et al., 2022; Kent & Haruta, 2024).

In practice, scalability is realized through mechanisms such as standardized interdisciplinary pathways, cross-setting collaboratives, and digital coordination tools. Thaker et al. (2022) illustrate how structured care pathways for heart failure institutionalized IPC into discharge planning, while Davidson et al. (2017) describe how hospital–SNF collaboratives align cross-organizational goals to improve outcomes. Digital models like ECHO-CT show how technology-enabled case reviews can be adapted across geographies, further reinforcing scalability (González et al., 2020). These examples demonstrate that sustainability is more than training it is institutional design.

The COVID-19 pandemic tested the resilience of IPC systems. Chovanec & Howard (2021) report that virtual care coordination models maintained communication and patient support despite workflow disruption, highlighting adaptability as a pillar of sustainability. Moreover, IPC structures that supported staff well-being during crises, such as collective leadership and shared accountability, proved critical to sustaining functionality under pressure (Ruttmann et al., 2024).

Reported Long-Term Impacts of IPC Implementation on Transitional Care

Long-term impacts of IPC are most consistently documented in patient-reported outcomes such as self-care capacity, transition preparedness, and post-discharge health status. Studies show that interventions incorporating education and structured follow-up particularly for chronic conditions can lead to sustained improvements in knowledge, quality of life, and coping (Tinoco et al., 2024; Xie et al., 2018). The link between IPC and these outcomes lies in interprofessional coordination of education, medication reconciliation, and care planning, all of which enhance the patient's ability to manage post-discharge care (Chartrand et al., 2023; Kinard et al., 2023).

Evidence on utilization outcomes like readmissions and emergency visits is more mixed. While some randomized trials show reduced readmission rates up to 90 days (Xie et al., 2018), others particularly those affected by the pandemic show limited or inconsistent impact (Toles et al., 2023). Structural modeling based on CTM data found no association between patient-perceived transition quality and readmission, suggesting that system-level or contextual factors may mediate this relationship (Marsall et al., 2024; Weber et al., 2020).

However, improved transition quality has been linked to better health status and fewer medication complications, reinforcing the idea that IPC impacts may be realized in domains beyond traditional utilization metrics (Saunders et al., 2021). Still, attribution to IPC mechanisms remains difficult due to limited measurement of team processes in many studies (Brown et al., 2024; Jesus et al., 2024).

Overall, while long-term effects on health system use remain variable, the evidence base supports IPC's role in promoting safer and more empowering transitions. To isolate and enhance these effects, future research must strengthen fidelity, measure interprofessional processes explicitly, and account for system disruptions (Werner et al., 2016)

Leadership and Feedback Mechanisms as Mediators of IPC Success

Effective leadership is repeatedly highlighted as a key enabler of IPC, particularly in addressing professional hierarchy and cultivating shared accountability. In hospital settings, lack of leadership and entrenched seniority systems hinder IPC enactment even when staff perceive collaboration positively (Kurniasih et al., 2022). Research on interprofessional socialization and teamwork emphasizes the need for team-centered accountability and collective leadership to replace uni-professional centrism (Keshmiri, 2022).

In high-pressure clinical settings, leadership becomes even more critical. Lin et al. (2021) describe how collective leadership during ICU resuscitations contributes to patient safety. During the COVID-19 pandemic, shared leadership and trust allowed transitional care teams to maintain coordination under disrupted conditions, demonstrating leadership's buffering role during system shocks (Chovanec & Howard, 2021).

Feedback mechanisms such as PDSA cycles, standardized event reporting, and validated measurement tools are equally essential. Thaker et al. (2022) illustrate how iterative improvement cycles support IPC adaptation. Tools like ECHO-CT translate transition events into learning opportunities (González et al., 2020), while instruments like CTM provide outcome-linked feedback when psychometrically adapted (Flink et al., 2018; Marsall et al., 2024). Realist and implementation-science-informed approaches further help decode the “how” and “why” behind IPC success (Kanno et al., 2023).

Education and training also play a role but are not sufficient alone. While simulations and interprofessional education improve IPC competencies (Maerten-Rivera, 2019), their impact is moderated by organizational culture and leadership. Training must be supported by environments that reinforce interprofessional values and collaborative workflows (McLaney et al., 2022).

Lessons from International Best Practices in IPC Integration

International experiences underscore that IPC best practices are context-sensitive. Brown et al. (2024) found that while team-based transitional care is valued across countries, few studies rigorously evaluate IPC strategies quantitatively. Cultural and educational system differences influence what IPC looks like in practice and how it is taught, making adaptation central to effective integration (Kent & Haruta, 2024; Weerd et al., 2024).

Case studies show that even well-designed interventions like structured information sharing may fail to improve outcomes if contextual alignment is poor. For example, Japan's early transfer trial showed no improvement in patient satisfaction (Ozaki et al., 2023), and Belgium's integrated care initiatives yielded no differences in patient experience or quality of life (Leithaus et al., 2023). These results caution against assuming one-size-fits-all effectiveness.

Despite variation, some design elements emerge as transferable: role clarity, communication routines, and validated measurement systems. Studies repeatedly identify lack of role definition and responsibility confusion as IPC barriers (Shirley et al., 2018). Standardized rounds and discharge planning routines support structured interprofessional communication, and

measurement tools like CTM and CPAT when locally validated provide feedback loops for continuous improvement (Ardyansyah et al., 2024).

Digitally enabled IPC offers further opportunities for cross-setting integration. Teleconferencing models (e.g., ECHO-CT) and remote discharge planning have shown feasibility during crises, while studies emphasize the need for shared electronic documentation to reduce patient coordination burdens (Durocher et al., 2023; Sekanina et al., 2024).

Ultimately, IPC integration must align with people-centred care principles, but implementation challenges persist. While WHO's IPCHS vision provides a guiding framework (Khatri et al., 2023), mixed results in transitional care effectiveness and persistent fidelity gaps underscore the need for stronger evaluation and adaptation (Jesus et al., 2024). International best practice is therefore not a static model but a set of principles clarity, continuity, and context-sensitive design that must be locally realized.

CONCLUSION

Interprofessional collaboration (IPC) in transitional care represents a crucial pillar for improving patient safety, continuity of care, and health outcomes. This study's synthesis affirms that IPC implementation success hinges on multidimensional determinants ranging from structural clarity and communication reliability to supportive organizational culture and robust feedback mechanisms. The analysis of literature has consistently emphasized that IPC is not merely a clinical practice ideal but a systemic necessity, particularly within complex patient transitions where multiple professionals, sectors, and settings intersect.

Structural and role clarity emerged as foundational for effective IPC. Evidence points to persistent role ambiguity, fragmented responsibilities, and professional hierarchies as recurring obstacles. These elements disrupt accountability and impair smooth coordination across the continuum of care. Communication-related barriers further compound these issues, with studies highlighting frequent miscommunications during handoffs, inadequate discharge education, and lack of shared documentation platforms. The integration of standardized tools like SBAR and multidisciplinary case conferences has demonstrated value in mitigating such failures, although widespread adoption remains uneven.

Human resource constraints, such as high workload and caseload imbalance, have also been identified as major IPC barriers, particularly when team members lack time or systemic support to engage in meaningful coordination. Organizational culture plays a vital mediating role; institutions that cultivate interprofessional trust, flatten hierarchical dynamics, and embed collaborative competencies into everyday practice show greater IPC resilience. This finding intersects with the recognized importance of leadership and collective accountability, both of which shape how team members engage with IPC norms and practices.

Sustainability and scalability of IPC require transitioning from programmatic efforts to infrastructure-level solutions. Team competency frameworks, cross-setting coordination collaboratives, and integrated feedback loops offer scalable mechanisms to institutionalize IPC.

Particularly under conditions of system shock, such as the COVID-19 pandemic, IPC systems that included digital communication infrastructure, adaptive care pathways, and robust leadership proved more resilient and sustained care continuity. Evidence also supports the integration of patient-reported outcome measures (e.g., CTM) and event classification systems to monitor implementation fidelity and outcomes, thereby reinforcing IPC quality improvement as a continuous learning process.

Although long-term impacts of IPC interventions remain inconsistently reported, the literature suggests stronger and more consistent improvements in patient-reported outcomes such as preparedness, understanding, and post-discharge coping than in objective utilization metrics like readmissions. These outcomes, inherently shaped by interprofessional discharge education and follow-up coordination, highlight the tangible benefits of well-executed IPC. However, attribution challenges persist, as many studies fail to isolate IPC-specific mechanisms or to evaluate longitudinal sustainability. This underscores the need for future research to apply rigorous, implementation science-informed methodologies to disentangle IPC's unique contributions within transitional care interventions.

From a policy and practice perspective, the findings advocate for embedding IPC into health system governance structures, with support for role clarity, team-based training, validated measurement, and culturally adapted frameworks. International evidence reinforces that while best practices in IPC are broadly transferable, their implementation must be sensitive to local cultural and infrastructural contexts. The convergence of insights across settings highlights IPC not as an optional enhancement, but as a structural requirement for safe, effective, and person-centered transitions. Future research should prioritize comparative implementation evaluations, fidelity-sensitive outcome tracking, and cross-context adaptation of IPC tools and competencies to advance both equity and quality in transitional care systems.

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