

THE COORDINATION GAP

Why Hospitals Have No Single System Aligning Care Teams Around the Patient

A Research Report for Healthcare Leaders Globally

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This report is the first in an ongoing research series examining the operational science of care coordination. Future editions will incorporate new evidence, implementation learnings, and emerging practices from health systems worldwide.

1. Executive Summary

Every hospital admission is, in effect, a relay race with no baton. A patient's care during a single inpatient stay passes through the hands of physicians, bedside nurses, lab technicians, dieticians, therapists, case managers, and pharmacists — often a dozen or more distinct actors, each operating from their own task list, their own system of record, and their own definition of "done." Not one of them is failing at their job. What's missing is the layer above all of them: a shared, continuously updated understanding of where this patient stands, right now, relative to a successful discharge.

Hospitals have invested heavily in systems of record. The EHR captures what happened. Lab and imaging systems track specimens and studies. Nursing platforms manage tasks and vitals. Nutrition, therapy, and case management each have their own tools.

> "***But a System of Record is not a System of Care Coordination — it tells you what was documented, not what needs to happen next, by whom, in what order, for this specific patient to move safely toward discharge."***

That coordination work still happens the way it has for decades: verbally at rounds, on whiteboards, over pages, and inside the judgment of whichever case manager or charge nurse happens to be holding the most context that day.

The stakes of that gap are not abstract. The Joint Commission has long identified inadequate hand-off communication as a leading contributing factor in serious patient safety events, and independent analyses of its sentinel event data have repeatedly put communication failures at care transitions behind an estimated 70 to 80 percent of the most serious reported cases. A gap this consequential deserves its own category, not a feature line on someone else's roadmap.

This report observes that the missing **System of Care Coordination** — not any single department's workflow — is the actual point of failure in inpatient care delivery. We map a single patient's journey from admission to discharge across seven stages and show, stage by stage, where the actor responsible changes, the system of record changes, and the information that should travel forward is instead reconstructed, delayed, or lost. We term these moments "**silent handoffs**": transitions with no built-in mechanism to confirm that what the sending actor knew is what the receiving actor now knows.

We then observe that the AI wave currently reaching hospitals — ambient scribes, coding assistants, single-user copilots — addresses individual actors' workload, but not the coordination gap between them. The next layer, we believe, is a **System of Care Coordination** in the fullest sense: an agent aligned to each actor's role, all oriented toward one shared objective — this patient's successful discharge — coordinating with each other the way the actors themselves are meant to, but frequently cannot, given the volume and pace of a modern hospital floor. Realizing this depends on a precondition most hospitals haven't yet met genuine interoperability between the systems each actor already uses, via standards like FHIR, rather than another point solution added to an already fragmented stack.

The report closes with two metrics for evaluating whether a System of Care Coordination is actually working, a readiness framework for assessing how prepared a given hospital's technology stack is for one, and a set of

questions hospital leaders — CMIOs, VPs of Care Management, CNOs, and CFOs — should be asking any vendor claiming to solve care coordination in 2026.

A note on sources: findings in this report draw on published research on handoff communication and care coordination, publicly available workforce and interoperability data, and primary field research conducted with health system partners. Partner-specific details have been generalized to protect confidentiality; where a claim depends on a specific published source, it is cited in place.

SYSTEM OF CARE COORDINATION (n.)

The layer of software that keeps every actor in a patient's care team — physician, nurse, lab technician, dietician, case manager — synchronized around one shared, continuously updated view of the patient. Distinct from a system of record, which documents what already happened, and from single-user AI tools, which make one actor faster without connecting them to the others.

2. Mapping a Single Patient's Journey — Admission to Discharge

To make the coordination gap concrete, we mapped a single, uncomplicated inpatient stay — no ICU escalation, no unusual comorbidities — across seven stages, from admission through discharge. At each stage, we identified who is primarily responsible, which system of record they use, what must happen for the patient to progress, and where the handoff to the next stage is exposed.

Two patterns hold across nearly every stage. First, the actor changes far more often than the system does — meaning most “handoffs” are happening inside a single tool that was never designed to alert the next responsible person. Second, the artifact expected to carry context forward (a note, a summary, a verbal update at rounds) is almost always static and point-in-time, while the patient's status is continuous. The table below lays out the full chain.

Stage	Primary Actor(s)	System / Tool of Record	What Has to Happen	Coordination Gap at Handoff
Admission	ED physician, admitting nurse, bed management	EHR (admission order set), bed board / ADT feed	Diagnosis captured, admission orders placed, bed assigned, nursing unit notified	Admitting intent (working diagnosis, anticipated length of stay, care goals) rarely travels with the patient beyond the note — the receiving nurse reconstructs it from the chart, not from the admitting physician's reasoning.
First 24 Hours	Attending physician, bedside nurse, pharmacist	EHR (orders, MAR), e-prescribing / pharmacy system	Med reconciliation, care plan established, baseline labs ordered, risk screens completed (falls, nutrition, DVT)	Screens and orders are logged in separate modules; no single view shows the nurse which flagged risks (e.g., nutrition, fall) have yet to be actioned by the responsible actor.

Stage	Primary Actor(s)	System / Tool of Record	What Has to Happen	Coordination Gap at Handoff
Daily Rounds	Attending, residents, bedside nurse, case manager	EHR notes, verbal rounding, whiteboard / paper lists	Plan of care updated, discharge barriers identified, tasks assigned across roles	Rounding decisions are frequently verbal or handwritten. Nurses, case managers, and ancillary staff who aren't physically present at rounds learn the updated plan late, or second-hand.
Diagnostics	Ordering physician, lab technician, radiology tech, nurse	LIS (lab system), RIS/PACS (imaging), EHR (results)	Sample collected or scan performed, result processed, ordering physician notified, plan adjusted	Lab and imaging systems are built to move a specimen or image through a pipeline — not to alert every actor whose plan for the patient depends on the result the moment it lands.
Nutrition & Ancillary Care	Dietician, physical/occupational therapist, nurse	Nutrition software, therapy scheduling tools, EHR	Nutritional and functional status assessed, care adjusted, restrictions communicated to nursing and food service	Dietary and mobility orders often live in systems the physician and nurse don't routinely check — a diet change or mobility restriction can lag a day or more behind the clinical decision that triggered it.
Discharge Planning	Case manager, social worker, attending, nurse	EHR (discharge module), payer portals, external facility referral systems	Discharge readiness assessed, post-acute placement arranged, medications and instructions prepared, follow-up scheduled	Discharge planning starts late relative to clinical readiness because barriers (placement, authorization, transport, caregiver availability) are surfaced only when someone remembers to ask — not continuously tracked from admission.
Discharge & Handoff Out	Nurse, case manager, receiving provider or facility	EHR (discharge summary), fax / portal to receiving facility, patient portal	Discharge summary generated, prescriptions sent, follow-up appointments confirmed, receiving provider or facility briefed	The discharge summary is the single artifact expected to carry an entire admission's context forward — to a primary care physician, SNF, or home health agency that had no visibility into the stay as it happened.

What This Map Shows

Across a single, average-complexity stay, a patient's care passes through six to eight distinct systems of record and a comparable number of primary actors — none of whom has a continuously updated view of what the others now know. This isn't a marginal drain on staff time: a 36-hospital time-and-motion study of medical-surgical nurses found that ***care coordination activities alone consumed 20.6% of nursing practice time — roughly 86 minutes of a 12-hour shift*** — trailing only documentation as the largest single use of a nurse's working hours. That's time spent synchronizing with other actors, not time spent on direct patient assessment or care.

The discharge summary, the one artifact explicitly designed to carry an entire stay's context forward, is written retrospectively, at the end, by whichever clinician is on service — reconstructing a narrative that a System of Care Coordination should have been maintaining continuously from hour one.

This is the shape of the problem a System of Care Coordination has to solve: not adding another dashboard for any single actor to check, but maintaining one continuously current model of the patient's status, and surfacing the right next action to the right actor, in the system and moment they're already working in — the way a well-run care team does informally, at its best, when the same experienced charge nurse or case manager happens to be on shift.

Methodology notes: this journey map reflects a generalized clinical pathway synthesized from published workflow and handoff-communication literature and validated through field research with health system partners. It is intended to represent a common pattern of care coordination in US acute-care hospitals, not any single institution's specific workflow.

3. The Next Layer: A True System of Care Coordination

Most AI reaching hospital floors today is built for a single user. Ambient scribes save a physician time on documentation. Coding assistants speed up billing staff. Nursing copilots summarize a shift's worth of chart activity. Each of these tools makes one actor faster at their own task list — and each of them, by design, stops at the edge of that actor's role.

None of them touch the problem this report has mapped: that the actors themselves are only loosely synchronized with each other. ***A faster physician and a faster nurse are still coordinating the way they always have — verbally, at rounds, through a chart neither reads continuously.*** Single-user AI compounds individual productivity without closing the gap between people.

We think the next layer looks different in kind, not just degree: **a genuine System of Care Coordination, oriented around the patient rather than around any one role, with a presence in each actor's own workflow, all working from a shared, continuously updated understanding of where that patient stands**. Not a dashboard one more person has to check, and not a single “care coordination” tool bolted onto the EHR — something closer to each actor having a counterpart that watches for what's relevant to them specifically and stays synchronized with the counterparts watching for every other actor, so the coordination that today depends on a particularly sharp charge nurse or case manager can happen reliably, for every patient, on every shift.

This is a meaningfully harder problem than any single-user copilot. It requires reasoning across roles with different vocabularies, priorities, and tolerance for risk; it requires acting inside systems that were never built to talk to each other; and it requires enough trust from clinical staff to be additive rather than one more alert to ignore. We don't think a System of Care Coordination exists in any mature form in US hospitals today. Realizing it also depends on a precondition most hospitals haven't yet met — the next section lays out a simple framework for assessing where a given hospital's technology stack stands.

A Note on Where the Market Is Headed

As of mid-2026, several of the ambient documentation platforms that built their initial footprint on physician-facing notetaking have begun expanding outward — into billing and revenue cycle, prior authorization, payer-

facing workflows, and, through partnerships with smart-room and virtual monitoring vendors, into the inpatient environment itself. This is a natural and rational move: documentation sits at the centre of the clinical encounter, and it's a reasonable place to expand from.

But expanding outward from a single-actor starting point is architecturally different from being built for multi-actor coordination from the ground up. A platform whose trust, data model, and workflow logic were designed around one clinician's conversation with one patient carries that shape forward as it grows — typically by partnering with, or acquiring, point solutions for each adjacent workflow, rather than by natively reasoning across every actor's role at once. The distinction matters less for documentation-adjacent tasks like coding or prior authorization, where the physician is still the natural centre of gravity. It matters a great deal for care coordination specifically, where the nurse, the lab technician, the dietician, and the case manager are equally central actors, not adjacent workflows orbiting a physician's note. We'd encourage any hospital evaluating vendors in this space to ask, concretely, whether a given platform's coordination capability was designed around every actor from day one, or added as an integration on top of a single-actor foundation — the readiness framework and vendor questions later in this report are meant to help make that distinction concrete.

4. What This Requires: An Interoperability Readiness Framework

A System of Care Coordination of the kind described in the previous section is only as good as the data it can see, in real time, across every actor's system. Most hospitals' AI conversations today start with a specific tool — an ambient scribe, a discharge predictor — rather than with an honest assessment of whether the underlying data layer can support something broader. We think that assessment should come first. Below is a simple framework for evaluating where a hospital's technology stack stands, across four dimensions, independent of any specific vendor.

1. Data Connectivity

Can your EHR, lab system, pharmacy system, and ancillary tools (nutrition, therapy, case management) exchange data through modern APIs — specifically FHIR — or does moving data between them still depend on interface engines, batch exports, or manual re-entry? Level 1 looks like point-to-point HL7 interfaces-built years ago for specific reports. Level 4 looks like a live, query-able FHIR layer spanning every system an actor touches during a stay.

2. Real-Time Event Availability

When a lab result posts, a medication is administered, or a plan changes at rounds, does anything downstream know immediately — or only at the next scheduled sync or when someone manually checks? Level 1 is overnight batch updates. Level 4 is event-driven: a change anywhere triggers a notification everywhere it's relevant, within seconds.

3. Cross-System Identity and Context

Does a given patient, encounter, and care team map to the same identifiers across every system — or does each system have its own patient ID, requiring manual reconciliation to know that “patient 44192” in the LIS is the same

person as “MRN 8827331” in the EHR? Without this, no System of Care Coordination can safely reason across systems at all, regardless of how sophisticated its AI is.

4. Governance and Clinical Trust

Is there an existing process for validating AI-surfaced information before it reaches a clinician — who's accountable when an automated alert is wrong, and how quickly can staff learn to trust or override it appropriately? Level 1 has no such process yet. Level 4 has a clinical governance body that's already validated at least one AI-driven workflow change and tracked its outcomes.

Published data suggests most hospitals still have real ground to cover here: as of 2023, only 43 percent of non-federal acute care hospitals routinely engaged in all four core interoperability domains — sending, receiving, finding, and integrating outside data — even though nearly all hospitals have had a certified EHR for years. That gap between having an EHR and operating as an interoperable system is the real bottleneck for a System of Care Coordination, and it's a data and governance problem before it's an AI problem. Any hospital evaluating vendors in this category should know its own position on this framework before evaluating anyone else's product against it.

5. Measuring a System of Care Coordination

A category this new doesn't yet have an agreed-upon way to measure whether it's working. Without one, every vendor conversation collapses into anecdote and demo footage. We propose two metrics — one leading, one lagging — that together give hospital leadership, and specifically finance, a way to evaluate a System of Care Coordination on the same terms as any other capital or operating decision.

Metric 1 | The Leading Indicator: Coordination Latency

Coordination Latency is the time between a status change relevant to a patient's care — a lab result posting, a plan changes at rounds, a discharge barrier surfacing — and every actor whose work depends on that information seeing it. It is, in effect, a direct measurement of the “silent handoffs” described throughout this report, expressed as a number rather than a pattern.

This is a process metric, not an outcome metric — it moves quickly, within days of a workflow change, and gives operational leaders something to act on immediately. Most hospitals can approximate a baseline for this today, without new technology, by sampling timestamp gaps already captured in existing EHR audit trails and system logs — the data usually already exists; it's just never been assembled to answer this specific question.

Metric 2 | The Outcome Metric: Avoidable Length-of-Stay Days

Avoidable Length-of-Stay Days measures bed-days attributable to coordination delay rather than clinical necessity — the gap between the date a patient is clinically ready for discharge and the date they actually leave, where that gap is caused by a coordination failure (a barrier surfaced too late, a discharge summary that took hours to route, a receiving facility notified only after the bed was needed) rather than a clinical or capacity constraint outside the hospital's control.

We favour this over readmission rate as the primary outcome metric for this category, though we'd encourage tracking both. Readmissions are meaningful but only loosely attributable to inpatient coordination specifically — they're also shaped by outpatient follow-up access, medication adherence, and social determinants the hospital doesn't control. Avoidable length-of-stay is caused almost entirely by what happens inside the walls, during the exact window this report maps, which makes it a cleaner test of whether a System of Care Coordination is working.

Why This Is a CFO Metric, Not Just an Operations Metric

Avoidable length-of-stay days translate directly into a hospital's own cost and capacity math: multiply the figure by a hospital's fully loaded cost per bed-day, or by the marginal revenue of an additional admission in a capacity-constrained unit, and the addressable financial impact becomes a number finance can defend to a board — without requiring this report, or any vendor, to supply a claimed savings figure. We'd encourage any hospital evaluating this category to run that calculation with its own numbers before evaluating anyone else's.

30-day readmission rate remains worth tracking alongside these two, not as the primary metric, but as an external, publicly benchmarked figure already tied to CMS reimbursement penalties — useful corroborating evidence once Coordination Latency and Avoidable Length-of-Stay Days establish that something has changed operationally.

As our deployments progress, we'll continuously incorporate real-world operational data and measured outcomes into this report. We believe the strongest benchmarks are those grounded in clinical practice, allowing this report to evolve alongside the evidence.

6. Questions to Ask Any Care-Coordination Vendor in 2026

The care coordination category is about to get crowded. Every vendor building anything adjacent to hospital operations will describe their product as solving coordination in 2026, because the term is broad enough to stretch over a scheduling tool, a messaging app, or a genuine System of Care Coordination. The questions below are meant to separate those quickly, organized by the leader most likely to be in the room.

For the CMIO / VP Digital Health

- Does this system read and write across the systems our actors already use (EHR, LIS, nutrition, pharmacy), or does it require staff to adopt one more standalone tool alongside what they already have open?
- What happens at the exact moment a plan changes at rounds — does every affected actor's view update automatically, or does someone still have to manually notify each person?
- How does the system handle FHIR-based integration with our specific EHR instance today, not in a roadmap — what's live in a production hospital right now?
- If two actors' agents (or systems) receive conflicting information about the same patient, what's the resolution path, and who is accountable for it?

For the VP of Care Management / Case Management

- Does this shorten the time between a discharge barrier becoming knowable and someone on the care team seeing it — and can you show that with a real before/after number from a live deployment, not a projected one?
- Does it change how early discharge planning starts relative to clinical readiness, or does it just make the existing discharge workflow faster?
- Who owns the relationship with post-acute and receiving facilities in this system's model — is the receiving provider still working from a static discharge summary, or does their visibility change too?

For the CNO / Chief Nursing Officer

- Does this add another screen or alert stream for bedside nurses to monitor, or does it surface information inside the workflow and system nurses already use?
- Has this been validated with nursing staff directly, and can you speak to a specific unit or shift where it changed how coordination happened, not just how it was reported to leadership?
- What's the failure mode if the system is wrong or delayed — does it silently degrade to the current manual process, or does it actively mislead a nurse who trusts it by default?

For the CFO

- Can this vendor report Coordination Latency and Avoidable Length-of-Stay Days from a live deployment, in our own terms, or only proprietary metrics we can't independently verify or compare across vendors?
- What's the actual mechanism by which this is expected to reduce avoidable bed-days — a specific point in the discharge process, or a general claim about “efficiency” we'd have to take on faith?
- What does a realistic first 90-days baseline-measurement period look like, before any claimed improvement, so we're comparing against our own real numbers rather than an industry average?

Cutting Across All Three

- Ask to see the system working across at least two different actor roles simultaneously, live, not two separate single-user demos stitched together in a slide.
- Ask what “care coordination” meant in this vendor's product roadmap eighteen months ago — a category this suddenly popular attracts a lot of repositioning from adjacent products, and the answer tells you whether coordination was the founding thesis or a recent pivot.
- Ask whether the platform's data model and workflow logic were designed around every actor from the start, or whether coordination was added as an integration layered onto a foundation built for one role — the two produce very different products even when the marketing language looks identical.
- Ask for one reference site willing to describe what didn't work initially, not just the eventual success — genuine deployments in hospital operations are rarely clean on the first attempt, and a vendor with only polished references is a vendor you haven't stress-tested yet.

7. About

This report was produced by Anfiniti Consulting as part of our ongoing work applying the AI Native Executive Diagnostic — our framework for assessing where an organization sits on the path to becoming AI-native. We work with health system leadership to think clearly about what AI-native requires operationally, before any specific technology decision gets made.

During this research, our team has also been directly involved in building agentic care coordination software for healthcare service providers, currently deploying with an early health system partner. We mention this because it's the source of the operational depth behind this report's journey map — not because this report is an advertisement for that work. Our recommendation to any organization we brief is to reach a clear, independent view of the problem first, and treat any specific vendor, including ones we're connected to, as one option among several to evaluate afterward.

If the problem in this report is one your organization is actively working through, we'd welcome the conversation: **ravi@anfiniticonsulting.com**.

8. References

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Data points cited in this report are drawn from the above published sources. Field research findings, described elsewhere in this report, are based on primary work with health system partners and are not separately footnoted here to protect confidentiality, per the sourcing note in Section 1.

This report will be updated as newer editions of these data sources become available. Readers who want the full underlying studies or have questions about methodology are welcome to contact us at the address above.