Position Statements

Care Coordination and Registered Nurses' Essential Role

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Purpose:

Care coordination is a necessary foundation to achieving the "triple aim" of health reform – improved patient experience of care (quality, access and reliability), improved population health, and per capita cost control (IHI, 2011). This position statement articulates the essential role of the registered nurse in the care coordination process. The American Nurses Association (ANA) is deeply committed to improving health outcomes and the quality of life for healthcare consumers and providing greater efficiencies through care coordination centered on the needs and preferences of healthcare consumers and their families.

Statement of ANA's Position:

The American Nurses Association recognizes and promotes the integral role of registered nurses in the care coordination process to improve healthcare consumers' care quality and outcomes across patient populations and health care settings, while stewarding the efficient and effective use of health care resources.

(1) Patient-centered care coordination is a core professional standard and competency for all registered nursing practice. Based on a partnership guided by the healthcare consumer's and family's needs and preferences, the registered nurse is integral to patient care quality, satisfaction, and the effective and efficient use of health care resources. Registered nurses are qualified and educated for the role of care coordination, especially with high risk and vulnerable populations.

(2) In partnership with other healthcare professionals, registered nurses have demonstrated leadership and innovation in the design, implementation, and evaluation of successful team-based care coordination processes and models. The contributions of registered nurses performing care coordination services must be defined, measured and reported to ensure appropriate financial and systemic incentives for the professional care coordination role.

History/Previous Position Statements:

The American Nurses Association's Nursing: Scope and Standards of Practice: (2nd ed., 2010) clearly delineates the registered nurse's responsibility and accountability for care coordination across patient populations and settings. Specific professional care coordination competencies for the registered nurse are:

- Organization of care plan components;
- Management of healthcare consumers' care to maximize independence and quality of life;
- Assistance to healthcare consumers in identifying care options;
- Communication with the healthcare consumer, family and members of the health care system, especially during transitions in care;
- Advocacy for delivery of dignified care by the inter-professional team; and
- Documentation of coordination of care.

Additional competencies for the registered nurse with graduate level specialty preparation and the advanced practice registered nurse (APRNs) are:

- Leadership in the coordination of inter-professional healthcare for integrated delivery of healthcare services; and
- Synthesis of data and information to prescribe necessary system and community support measures (ANA, 2010).

The American Association of Colleges of Nursing (AACN) lists, among the essential competencies for a generalist baccalaureate nursing degree, processes of care coordination. These include:

- Implementing holistic, patient-centered care across the health/illness continuum, across the lifespan, and in and among all healthcare settings;
- Communicating effectively with all members of the healthcare team, including the patient and the patient's support network; and
- Discerning the variation and complexity inherent in caring for vulnerable populations, including a capacity to evaluate and optimize available healthcare resources (2008).

The activities associated with these competencies are not delegated tasks. They are part of registered nursing's independent scope of practice. RNs are "informed decision-makers whose independent actions are based on education, evidence, and experience" (IOM, 2011, p. 223).

Additional support for the care coordination role of the registered nurse is found in ANA's Code of Ethics for Nurses (2001), which reflects nursing's responsiveness to a changing health care system and the context in which health care is provided. These provisions recognize the registered nurse as advocate for healthcare consumers, families, and the public. Specific provisions also speak directly to the registered nurse's fundamental role in providing interprofessional collaboration and communication to reach shared, patient-centered goals. The Code of Ethics acknowledges professional

commitment to advancement of professional practice, quality health care for all and attainment of national health goals (ANA, 2001).

ANA and the nursing profession continue to lend their expertise to the ongoing work on care coordination by collaborating with prominent national healthcare quality organizations, including the Institute for Healthcare Improvement, the National Quality Forum, the Partnership for Patients, and the National Priorities Partnership (IHI, 2011; NQF, 2011; Partnership for Patients, 2011; NPP, 2011). These collaborations have accelerated discussions about care coordination throughout major national professional groups seeking solutions to improve the health of the population, enhance the healthcare consumer's care experience, and reduce or control the cost of care.

The lack of effective care coordination for individuals across settings results in increased cost, potential drug interactions, increased medical error, and unnecessary duplication of tests and services, often occurring when healthcare consumers are shuttled from provider to provider with chronic, complex or hard to diagnose conditions (IOM, 2003). Most important, it increases the cost in human suffering for healthcare consumers and their families. A sense of urgency accompanies the intensive work taking place within the healthcare community, to meet the demands of a quickly evolving health care environment to better serve healthcare consumers.

Supportive Material

Defining Care Coordination

Care coordination has been defined by numerous groups, many of which focus on its application and implementation in the context of specific patient populations in specific settings (McDonald et al., 2007). Two respected organizations have devised complementary definitions, reflecting the challenge of succinctly capturing the breadth and depth of care coordination. The National Quality Forum (NQF) describes care coordination as "a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time" (2006, p. 1). The U.S. Agency for Healthcare Research and Quality (AHRQ) defines care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services" (2011, p. 189). While both definitions share the goal of achieving efficient and high quality patient-centered care, one focus is on "deliberate organization," whereas the other focus is on "functions."

Professional nursing integrates these approaches. Care coordination promotes greater quality, safety, and efficiency in care, resulting in improved healthcare outcomes and is consistent with nursing's holistic, patient-centered framework of care. A knowledgeable healthcare professional deliberately designated to coordinate care is necessary to effectively utilize resources within the set of complex health systems and multiple providers in accordance with patient and family care needs (McDonald et al., 2011; O'Malley, Tynan, Cohen, Kemper, & Davis, 2009).

Registered nurses are central to organizing the healthcare consumer's experience, among diverse populations and across settings. The care coordination process is one aspect of professional practice through which registered nurses at every level regularly influence the healthcare consumer's care. Given this influence, registered nurses enhance the value of care by their demonstrated contributions to successful quality care outcomes and increased efficiencies.

Nursing Innovation and Leadership in Care Coordination

Registered nurses are a vital part of any effort to design and implement care coordination systems within and among institutions, organizations, and communities. "Coordinating care is one of the traditional strengths of the nursing profession, whether in the community or the acute care setting" (IOM, 2011, p. 65). Registered nurses' well-documented capacity for problem-solving, innovation and adaptability and their engagement at multiple levels and settings in the healthcare system provide the foundation for excellence in the role of care coordinator. Therefore, discussions of care coordination strategies within the context of health care innovation must include the voice and leadership of the nation's more than three million registered nurses, the largest single group of healthcare professionals in the United States.

The influential 2011 Institute of Medicine report, "The Future of Nursing: Leading Change, Advancing Health," recommends that nurses become full partners with physicians and other healthcare professionals, acting as leaders in redesigning health care in the United States. This includes the design and implementation of care coordination systems and protocols (Gardner, 2005; Pearson, et al, 2007). The continued integration of the registered nurse in the care coordination role should be a deliberate achievement of design based on evidence based practice and performance improvement measures.

Registered nurses demonstrate improved health care value, which can be defined as the assessment of healthcare consumer outcomes over time relative to a system's resource investments (Porter, 2010). Measuring and achieving health care value is complex but essential (McDonald, et al., 2007). The National Quality Forum identified five domains essential to the measurement of care coordination: (1) the healthcare home; (2) a proactive plan of care and follow-up; (3) communication; (4) information systems; and (5) transitions, or handoffs (2006). Registered nurses lead or contribute significantly in each of these domains, which continue to evolve as foci of patient-centered care.

The positive influence of registered nurses in the care coordination role has been demonstrated in health care reform initiatives focused on integrated service delivery. Registered nurses have designed and implemented care coordination standards, protocols and practices that seek to improve patient outcomes and decrease costs, demonstrating the effectiveness of nurse-led and patient-centered care coordination (Allen et al., 2011; Boyd et al., 2009; Coleman, 2006; Naylor, Aiken, Kurtzman, & Olds, 2010; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011; Naylor et al., 1999).

Many such "practical innovators" in the nursing community are showcased by the American Academy of Nursing's (AAN) Edge Runners program, part of its *Raise the Voice* campaign for transformational health leadership (AAN, 2011). The Edge Runners program provides a platform highlighting pioneering care models and interventions that improve clinical and financial outcomes for large numbers of healthcare consumers in a variety of care settings. To date, over 50 nurse-driven programs in a variety of settings among various populations have been recognized for solutions reflecting new thinking in an ailing healthcare system. (AAN, 2011).

Nurses as Partners in Patient-Centered Care Coordination

Different care settings, the complexity of the healthcare consumers' needs, and resource availabilities will influence the selection of a care coordinator. For many healthcare consumers, the registered nurse is the most appropriate care coordinator within many primary, ambulatory and acute care settings. Other settings across the care continuum where specialized populations often require specialized care -- including schools, home care, and dedicated centers such as dialysis clinics -- benefit from registered nurses coordinating care, as well. The education, experience, and competence of the registered nurse will determine her or his aptitude for, and extent of, the care coordination role. In some cases, the healthcare consumer's multiple co-morbidities or complex needs may indicate that an advanced practice registered nurse (APRN) would be the most suitable care coordinator.

Registered nurses' skill sets include developing an individualized care plan with other members of the interprofessional team, especially for high-risk patients, healthcare consumers with targeted chronic health conditions, and their caregivers (Naylor et al, 2004). A report to the Medicare Administrator on best practices in care coordination recommended use of baccalaureate prepared registered nurses degrees as care coordinators (Chen, et al., 2000). In the Medicare Coordinated Care Demonstration pilot project, registered nurses provided care coordination resulting in reduced hospital readmissions and expenditures (IOM, 2011). These patients were often characterized by multiple co-morbidities, prior hospital readmissions, care provision across multiple settings, and high utilization patterns (Craig, Eby, & Whittington, 2011; Owens, 2010).

Registered nurses are active participants and partners with other healthcare professionals to promote more cost effective, high quality delivery of health care services (Katon et al., 2010; Rantz et al., 2011; Robles et al., 2011). Different members of the interprofessional healthcare team may offer the appropriate qualifications to meet the individual needs and preferences of the healthcare consumer, depending on the situation and setting. In an era of increasingly scarce resources, registered nurses and all healthcare professionals must be permitted to function to the greatest extent allowed by their education, experience, and scope of practice. In many instances skills will overlap, highlighting the care coordinator's additional role of seeking the best way for the care team to work together for a particular healthcare consumer. As the healthcare consumer's advocate, registered nurses engage with other members of the healthcare team, including the healthcare

consumer, family and caregiver, to facilitate cooperation and ensure that the healthcare consumer receives optimal care.

As the foundation of patient-centered healthcare, care coordination should be infused throughout registered nurses' curriculum and continuing education. Care coordination competencies should be assessed and the content expanded and deepened as registered nurses extend their education to address the needs of specialized populations and practice. Care coordination should be an explicit component of prelicensure as well as master's and doctoral nursing education and scholarship. Equally, it should inform the education of all other healthcare professionals to help create a common framework for collaborative work and shared goals (IOM, 2011).

A shared plan of care across settings, that is accessible and developed jointly with the healthcare consumer and family, provides the compass for coordinating care. Care coordination will often be achieved most effectively by a registered nurse with the education and skills to develop and implement a comprehensive, interprofessional plan of care that is focused on each healthcare consumer's and/or caregiver's unique resources, needs and preferences. The care coordinator must be able to proactively identify barriers to care and evaluate potential adjustments to the care plan when the healthcare consumer's condition or social support changes (Matthews et al., 2010).

Registered nursing competencies related to cognitive decision-making, communication, and counseling are required to address the needs of the healthcare consumer and the care team throughout the spectrum of care. Use of appropriate technology to support the care coordination role is vital to providing timely referrals, decision-making, counseling and other services. Healthcare organizations and systems have an obligation to maximize all healthcare team members' shared understanding of, and facility with, such technologies for this common purpose.

Creating Incentives for Care Coordination

The goals of patient-centered care coordination must be achieved by design and intent. To that end, improvement of future care delivery requires measuring the performance of all care providers, and analyzing and comparing processes and outcomes relative to principles of patient-centered care. It is essential to evaluate the evidence of nursing knowledge, education, and expertise in specific care coordination activities which produce quality care and improved patient outcomes (McDonald et al., 2011).

Care coordination is necessary to achieve the objectives of the triple aim of health system reform: to improve the quality of care delivered to healthcare consumers, increase population health, and increase efficiencies in resource allocation to lower the cost of care. Stakeholders must investigate, create, and promote innovative reforms to create direct financial incentives to encourage the accomplishment of these objectives. For this reason, it is important that institutions and organizations be prepared to properly support the care coordination function and the role of the registered nurse as the care coordinator

as a full partner within an interprofessional group of healthcare providers and healthcare consumers, families, and caregivers.

Summary:

1. Patient-centered care coordination is a core professional standard and competency for all registered nurses.
2. Registered nurses provide healthcare coordination based on a partnership guided by the healthcare consumer's and family's needs and preferences, as well as the optimal allocation of resources.
3. Care coordination should be infused throughout registered nurses' curriculum and continuing education. Care coordination competencies should be assessed and the content expanded and deepened as registered nurses extend their education to address the needs of specialized populations and practice. Care coordination should be an explicit component of prelicensure as well as master's and doctoral nursing education and scholarship.
4. Research should further examine registered nurses' evolving role and contributions to care coordination.
5. Care coordination activities, functions, and roles must be explicitly identified and funded to enhance incentives for cost-effective, high quality care**.**

References:

Agency for Healthcare Research and Quality (AHRQ). (2011). National healthcare disparities report. *(*AHRQ Publication No. 11-000*)*. Rockville, MD: AHRQ, from http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf

Allen, J. K., Himmelfarb, C. R., Szanton, S. L., Bone, L., Hill, M. N., & Levine, D. M. (2011). COACH trial: a randomized controlled trial of nurse practitioner/community health worker cardiovascular disease risk reduction in urban community health centers: rationale and design. *Contemporary Clinical Trials, 32*(3), 403-411.

American Academy of Nursing. (2011). Raise the voice, from http://www.aannet.org/i4a/pages/index.cfm?pageid=3301

American Association of the Colleges of Nursing. (2008). The essentials of bacclaureate education for professional nursing practice, from http://www.aacn.nche.edu/education-resources/BaccEssentials08.pdf

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Nursebooks.

American Nurses Association. (2010). *Nursing: scope and standards of practice*. Silver Spring, MD: Nursebooks.

Boyd, C. M., Reider, L., Frey, K., Scharfstein, D., Leff, B., Wolff, J., . . . Boult, C. (2009). The effect of guided care on the perceived quality of health care for multi-morbid older persons: 18 month outcomes from a cluster-randomized controlled trial. *Journal of General Internal Medicine, 25*(3), 235-242.

Chen, A., Brown, R., Archibald, N., Aliotta, S., Fox, P.D. (2000). Best Practices in Coordinated Care. Mathematica Policy Research, Inc. Report. Retrieved from http://www.cms.gov/DemoProjectsEvalRpts/downloads/CC_Full_Report.pdf).

Coleman, E. (2006). Care transitions model, from http://www.caretransitions.org/documents/Hartford%20Report%202007.pdf

Craig, C., Eby, D., & Whittington, J. (2011). Care coordination model: better care at lower cost for people with multiple health and social needs. *IHI Innovation Series white paper*, from http://www.ihi.org/knowledge/Knowledge%20Center%20Assets/Pages%20-%20CareCoordinationModelBetterCareatLowerCostforPeoplewithMultipleHealthandSocialNeeds_58e1bba1-9069-4099-8ae9-f17aac484695/IHICareCoordinationModelWhitePaper2011.pdf

Gardner, D.B. (2005). Ten lessons in collaboration. *Online Journal of Issues in Nursing* 10(1):2.

Institute for Healthcare Improvement. (2011). The IHI triple aim: better care for individuals, better health for populations and lower per capita costs, from http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st century. Washington, DC: The National Academies Press.

Institute of Medicine. (2003). Priority areas for national action: Transforming health care quality. Washington, DC: The National Academies Press.

Institute of Medicine. (2011). The Future of nursing: Leading change, advancing health. Washington, DC: The National Academies Press, from http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

Katon, W. J., Lin, E. H., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., . . . McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *New England Journal of Medicine, 363*(27), 2611-2620.

Matthews, J. H., Coe, T. R., Bruflat, C., Burnett, S., Howard, P., & Peterson, C. (2010). The Patient Lock Model©: A Continuum of Care. *Policy, Politics, & Nursing Practice, 11*(2), 132-139.

McDonald, K., Schultz, E., Pineda, N., Lonhart, J., Sundaram, V., Smith-Spangler, C., . . . Malcolm, E. (2011). Care coordination measures atlas. *AHRQ Publication No. 11-0023-EF*, from http://www.ahrq.gov/qual/careatlas/

McDonald, K. M., Sundaram, V., Bravata, D. M., Lewis, R., Lin, N., Kraft, S., . . . Owens, D. (2007). Closing the quality gap: a critical analysis of quality improvement strategies *Volume 7: Care coordination* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44015/pdf/TOC.pdf

National Priorities Partnership. (2011). National priorities partnership: a vision for world-class affordable health care, from http://www.nationalprioritiespartnership.org/Priorities.aspx

National Quality Forum. (2006). NQF endorsed definition and framework for measuring care coordination, from http://www.qualityforum.org/projects/care_coordination.aspx

National Quality Forum. (2011). National quality forum, from http://www.qualityforum.org/Setting_Priorities/NQF_in_the_Quality_Landscape.aspx

National Quality Forum. (2012). National voluntary consensus standards for care coordination 2012: Draft technical report, from http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70600.

Naylor, M., Aiken, L., Kurtzman, E., & Olds, D. (2010). Nursing's contributions to care coordination and transitional care: state of the science. *Robert Wood Johnson Foundation Nursing Research Network*. Retrieved from http://www.thefutureofnursing.org/sites/default/files/Research%20Brief-%20Nursing's%20Contributions%20to%20Care%20Coordination%20and%20Transitional%20Care.pdf

Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). The importance of transitional care in achieving health reform. *Health Affairs, 30*(4), 746-754.

Naylor, M. D., Brooten, D. A., Campbell, R. L., Maislin, G., McCauley, K. M., & Schwartz, J. S. (2004). Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. *Journal of the American Geriatrics Society, 52*(5), 675-684.

Naylor, M. D., Brooten, D., Campbell, R., Jacobsen, B. S., Mezey, M. D., Pauly, M. V., & Schwartz, J. S. (1999). Comprehensive discharge planning and home follow-up of hospitalized elders. *JAMA: The Journal of the American Medical Association, 281*(7), 613-620. doi: 10.1001/jama.281.7.613

O'Malley, A. S., Tynan, A., Cohen, G., Kemper, N., & Davis, M. (2009). HSC research brief No. 12: Coordination of care by primary care practices: strategies, lessons and implications. *Center for Studying Health System Change*. Retrieved from http://www.hschange.com/CONTENT/1058/

Owens, M. K. (2010). *The healthcare imperative: lowering costs and improving outcomes*. Washington, D.C.: The National Academies Press.

Partnership for Patients. (2011). Partnership for patients: better care, lower costs, from http://www.healthcare.gov/compare/partnership-for-patients/index.html

Pearson, A., Laschinger, H., Porritt, K., Jordan, Z., Tucker, D., and Long, L. (2007). Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. *International Jornal of Evidence-Based Healthcare.* 5:208-253).

Porter, Michael E. (2010). What is value in health care ? *New England Journal of Medicine, 363,* 2477-2481.

Rantz, M., Phillips, L., Aud, M., Popejoy, L., Dorman-Marek, K., Hicks, L., . . . Miller, s. (2011). Evaluation of aging in place model with home care services and registerd nurse care coordination in senior housing. *Nursing Outlook, 59*, 37-46.

Robles, L., Slogoff, M., Ladwig-Scott, E., Zank, D., Larson, M. K., Aranha, G., & Shoup, M. (2011). The addition of a nurse practitioner to an inpatient surgical team results in improved use of resources. *Surgery, 150*(4), 711-717.