POSITION STATEMENT

ANA
AMERICAN NURSES ASSOCIATION

THE ESSENTIAL ROLE OF REGISTERED NURSES IN CARE COORDINATION

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Adopted by: ANA Board of Directors

Purpose

The American Nurses Association (ANA) recognizes and promotes the integral role of registered nurses in providing coordinated care for patients. Care coordination efforts in the health care delivery system improve quality, experience, and outcomes across patient populations and settings. At the same time, nurses remain key stewards of the efficient and effective use of resources throughout the provision of coordinated health care services. In this position statement, ANA articulates the essential role of the registered nurse in leading these efforts and highlights the importance of the registered nurse in the development of and compensation under future care coordination models.

Statement of ANA Position

Registered nurses routinely coordinate with members of patients' health care teams every day in the course of delivering health care services to patients, whether in acute care, long-term care, private practice, or other settings. Patient-centered care coordination is a core professional standard for all registered nurses and is central to nurses' longtime practice of providing holistic care to patients—incorporating interventions from a variety of disciplines into traditional health care approaches. For these reasons, the ANA supports the promotion and involvement of registered nurses in the development of future care coordination models. Specifically, the ANA believes that registered nurses must be:

(1) **Recognized as essential to successful care coordination in the nation's health care delivery system.** This recognition must come from policymakers, health care professionals, and payers.

(2) **Appropriately compensated for the services they provide to patients and families.** There must be payment parity across all qualified health professionals for the scope of services they provide in delivering high-value care coordination.

(3) **Included in the design and endorsement, and use of rigorously tested care coordination measures, which are central to the domain of nursing.** The contributions of registered nurses performing care coordination services must be defined, measured, and reported to inform and ensure appropriate financial and systemic incentives for the professional care coordination role.

What Is Care Coordination?

The nation's health care delivery system is marred by high costs, inconsistent quality, and inequitable health outcomes. Even though the United States spends more on health care, per capita, than any other nation, our fragmented system is often characterized by breakdowns in communication and unnecessary or redundant tests and services.[i] To mitigate these problems, health care providers and payers are increasingly turning to care coordination models to improve the delivery system and keep patients out of more costly acute care settings.

Numerous groups have defined "care coordination." Many of them focus the definition on its application and implementation in the context of specific patient populations in specific settings.[ii] 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."[iii] The 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."[iv]

While both definitions describe the goal of achieving efficient and high-quality patient-centered care, one focuses on function whereas the other focuses on structure. Professional nursing integrates these approaches in a way that is consistent with nursing's holistic, patient-centered framework of care, using care coordination to promote high-quality, safe, efficient care and improved health care outcomes. Such integration would necessitate officially designating a knowledgeable health care professional to coordinate care (function) in order to effectively use the resources of complex health systems and multiple providers (structure) in accordance with patient and family needs and preferences.[v,vi]

The Role of the Registered Nurse

Registered nurses are central to organizing and supporting the patient's health care experience, among diverse populations and across care settings. One way they regularly influence the patient's care is through care coordination. Their care coordination decisions contribute to successful outcomes and increase efficiency, thereby enhancing the value of care.

Registered nurses are a vital part of any effort to design, implement, and evaluate care coordination systems within and among institutions, organizations, and communities. Care coordination has long been recognized as a traditional strength of the nursing profession, regardless of the care setting.[vii]

Registered nurses' well-documented capacity for problem-solving, innovation, and adaptability and their engagement at multiple levels and in settings throughout the health care system provide the foundation for excellence in the role of care coordinator.

Therefore, discussions of care coordination strategies in the context of health care innovation must include the voice and leadership of the nation's 4.2 million registered nurses, the largest single group of health care 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 health care professionals and assume leadership roles in redesigning health care in the United States—including the design and implementation of care coordination systems and protocols.[viii,ix]

Registered Nurses as Partners in Patient-Centered Care Coordination

Type of care setting, health care consumer needs and preferences, and available resources will influence the selection of a care coordinator. For many health care consumers, the registered nurse is the most appropriate care coordinator within many primary, ambulatory, and acute care settings. Settings devoted to specialized populations, such as schools or dialysis and oncology clinics, often benefit as well when registered nurses coordinate care. A registered nurse's education, experience, and competence will help determine the nurse's potential impact in the care coordinator role. Registered nurses' skill sets include the ability to develop individualized care plans with other members of the interprofessional team, especially for high-risk patients, health care consumers with targeted chronic health conditions, and patients' caregivers.[x]

In an era of increasingly scarce resources, registered nurses must be permitted to function to the greatest extent allowed by their education, training, experience, and scope of practice. Ensuring that nurses are occupying roles at the top of their abilities and that the team is functioning most efficiently, especially when health care team members' skills overlap, is a key responsibility of the care coordinator. As a patient advocate, registered nurses often fill this role as well, engaging with other health care team members, including the family and caregivers, to facilitate collaboration and ensure that patients receive optimal care.

Registered nurse competencies related to cognitive decision-making, communication, and counseling are required to address the needs of the health care consumer and the care team across the spectrum of care. Technology is key to administering these competencies and is also another area of expertise. Use of appropriate technology to support the care coordination role is also vital to providing timely referrals, decision-making, counseling, and other services. In addition, use of technology such as the electronic health record to capture outcomes and nurse contributions is critical to measuring and advancing successful care coordination. Health care organizations and systems have an obligation to maximize all health care team members' shared understanding of and facility with such technologies for these common purposes.

Care Coordination Integral to Nursing Education Curricula

Because it is foundational to patient-centered health care, care coordination content should be embedded throughout registered nurses' educational prelicensure as well as master's and doctoral

nursing education curriculum and continuing education experiences. As registered nurses extend their education, care coordination content should be expanded and deepened to address the needs of specialized populations, and necessary competencies should be evaluated. Equally important, care coordination content must be incorporated into the education of all other health care professionals to help develop shared goals and a common framework for collaborative work.[xi]

Care Coordination in Nursing Scope and Standards, and Code of Ethics

The American Nurses Association's *Nursing: Scope and Standards of Practice* (2021) clearly delineates the registered nurse's responsibility and accountability for care coordination in Standard 5A: Coordination of Care, which states, "The registered nurse coordinates care delivery."[xii] The registered nurse is expected to demonstrate the following associated competencies, as the following makes clear:

- Collaborates with the health care consumer and the interprofessional team to help manage health care based on mutually agreed-upon outcomes.
- Organizes the components of the care plan with input from the health care consumer and other stakeholders.
- Manages the health care consumer's care to reach mutually agreed-upon outcomes.
- Engages health care consumers in self-care to achieve preferred goals for quality of life.
- Helps the health care consumer identify options for care and navigate the health care system and its services.
- Communicates with the health care consumer, interprofessional team, and community-based resources to effect safe transitions for continuity of care.
- Advocates for the delivery of dignified and holistic patient-centered care by the interprofessional team.
- Documents the coordination of care.[xiii]

ANA's *Code of Ethics for Nurses* (2015) supports the central role of the registered nurse in care coordination by emphasizing the registered nurse's role in collaborating with patients and caregivers and elevating patient self-determination. It reflects nursing's responsiveness to a changing health care system and the context in which health care is provided.[xiv] The *Code of Ethics* explains that the patient, family, or caregiver is at the center of care coordination needs, and that registered nurses are advocates for these individuals' role in self-management and shared decision-making.[xv] Specific provisions also speak directly to the registered nurse's fundamental role in providing interprofessional collaboration and communication to reach shared, patient-centered goals.

Incentives and Payment Parity for Nurse-Led Care Coordination Models

The goals of patient-centered care coordination must be achieved by design and intent—and the patient and/or caregivers and health care team must be central to achieving these goals. To that end, improving care delivery requires analyzing processes and measuring outcomes that reflect all clinicians' roles in

patient-centered care. It is essential to evaluate the evidence that nursing knowledge, education, and expertise in specific care coordination activities produce quality care and improved patient outcomes.[xvi]

Stakeholders must seek, develop, and promote innovative reforms that create direct financial incentives to control costs while delivering improved quality of care for patients. To make this possible, institutions and organizations must properly support the care coordination function and the role of the registered nurse as care coordinator and as a full partner within an interprofessional group of health care providers and health care consumers, families, and caregivers.

Delivery system reform efforts have been supported through authorities granted by statutes and regulations or agency guidance, largely pertaining to the Medicare and Medicaid programs. Many new models have resulted from authority granted to the Center for Medicare and Medicaid Innovation (CMMI) to waive provisions of law and regulations in order to allow for delivery system improvements. These reform initiatives largely feature some aspect of care coordination. Increasingly, we are seeing alignment across the Medicare and Medicaid programs and commercial health insurance, as all payers of health care services increasingly seek to improve quality while controlling costs.

Medicare

The Medicare program uses numerous models and payment systems—made possible either through existing provisions of Medicare statutes and regulations or through authority granted by CMMI—to foster care coordination for beneficiaries. Some models and demonstration projects target patients with chronic conditions, behavioral health or substance use disorders, and others focus on certain services, such as primary care or oncology. Arrangements under various models and demonstration projects include accountable care organizations, which encourage providers to work together and deliver high-quality, coordinated care to Medicare patients, and health homes.

Most recently, we have seen new initiatives such as the Bundled Payment for Care Initiative, which uses bundled payments for multiple services beneficiaries receive during an episode of care, to drive financial and performance accountability—often leading to higher-quality, coordinated care at a lower cost to the Medicare program. Many existing models recognize registered nurses' involvement in care coordination and management in these initiatives.

Recent changes in Medicare policy have provided opportunities for registered nurses to be more independent in care coordination activities than they have in the past, which in many instances has resulted in significant shared savings. However, most payments to registered nurses for care coordination activities must go through a physician or another provider who can direct-bill Medicare. This continues to present a barrier for nurse-led care coordination efforts targeting Medicare beneficiaries.

Medicaid

Increasingly, federal efforts provide support and incentives to states to incorporate models that feature care coordination for Medicaid beneficiaries—with the goals of improving outcomes and controlling costs. These efforts are supported through payment incentives that not only reimburse for care coordination services but also provide opportunities to reinforce the role of the registered nurse. For example, under existing statute, state Medicaid programs have the option to provide care coordination

through a health home for patients with chronic conditions, and to pay for this care coordination using payment methodologies for services provided by a "team of health care professionals." Of importance, the statutory language specifically references nurse care coordinators.[xvii]

A new focus on encouraging and providing incentives for care coordination has appeared in Medicaid managed care. States increasingly are turning to managed care delivery systems to manage their Medicaid populations, with managed care organizations (MCOs) accepting capitated payments from the state for services provided to beneficiaries. The nature of these contracted arrangements encourages providers to use care coordination to manage costs. Many states have used contracts with MCOs to implement a range of initiatives and models to promote coordinated care efforts—for example, by tying payment incentives to performance goals while holding MCOs accountable for high-quality care.[xviii]

States have also used program flexibilities to drive delivery system reform, such as through Section 1115 demonstration waivers and other models. In September 2020, the Centers for Medicare & Medicaid Services (CMS) issued a state Medicaid directors letter detailing the value-based care opportunities in the Medicaid program and the flexibilities available to states to adopt models that seek to improve patient health while reducing costs, such as quality-based pay for performance, partial capitation, and health homes.[xix]

Commercial Insurance

All commercial health insurance plans offer beneficiaries some level of care coordination services and supports—as, increasingly, they adopt patient-centered care models.[xx] Many commercial plans use care coordination for patients with chronic conditions, to improve quality while controlling costs.[xxi] Similar efforts address the complex needs of beneficiaries with behavioral health needs through integration and coordination of health care services.[xxii] Health plans typically utilize financial incentives and other policies to support and promote the adoption of care coordination activities for covered patients. Moreover, many plans work directly with clinicians—including registered nurses—to improve care coordination by providing patient data and other supports.[xxiii] Such care coordination activities (targeting health conditions or patient populations) bring commercial health plans more into alignment with public health plan innovations and initiatives.

While it is encouraging to see alignment across payers on the importance of providing and reimbursing for care coordination services, it is critical that the role of the registered nurse remain central. Federal and state policymakers must continue to provide payment and programmatic incentives that support and reward nurse-led care coordination models. Payment parity for services provided by registered nurses is essential given that registered nurses are strong advocates for patients, their families, and the community, and achieve shared patient-centered goals through their ongoing engagement with multidisciplinary teams.

Measuring Care Coordination

The identification and development of measures that capture care coordination services and activities are critical not only to the success of innovative models and approaches, but also to ensuring payment parity for rendered services. Measures must capture not only outcomes, but also registered nurses' contributions in the provision of coordinated care to patients. Additionally, measures must seamlessly integrate into existing electronic health record workflows and processes to ensure accurate measurement without adding administrative burden that detracts from patient care. Lastly, services or

processes vital to care coordination that are difficult to capture or cannot be measured must not penalize clinicians. Rather, alternatives must be identified and incorporated in any measure set to allow for accurate assessment of care coordination activities.

ANA continues to encourage the U.S. Department of Health and Human Services, CMS, subagencies, and other policymakers, as well as health care organizations, to thoughtfully research and identify applicable, sound measures that capture care coordination efforts. ANA also encourages policymakers to look to research bodies, such as the National Institute of Nursing Research, part of the National Institutes of Health, to provide clinical guidance and evidence to help identify appropriate measures that capture care coordination activities and the crucial role of registered nurses in these efforts.

Recommendations

As policymakers, health care organizations, and payers implement care coordination models, ANA continues to advocate for the importance of registered nurses' care coordination role, recognition of their contributions, and their inclusion in developing and playing a central role in these models. Registered nurses not only are important advocates for patients and their families, but also are key to collaboration and communication across multidisciplinary teams to reach shared, patient-centered goals. Therefore, ANA recommends:

1. Nurses must be acknowledged as leaders and full partners with physicians, other health care professionals, and patients in redesigning health care in the United States.
2. Existing and new payment mechanisms must recognize evidence-based practices and payment parity between nurses and other health care professionals.
3. Care coordination should be an explicit component of prelicensure curriculum as well as master's and doctoral nursing education and continuing scholarship. Related competencies should continually be evaluated, and the content expanded and deepened to complement the needs and preferences of specialized populations and practice.
4. Research must be supported to identify and examine metrics for evaluating outcomes and the contributions of registered nurses in care coordination activities and greater health care delivery system reform.

Summary

ANA is deeply committed to continuous improvements in health outcomes and quality of care for all. Registered nurses not only are important advocates for patients and their families but also are key to collaboration and communication across multidisciplinary teams to reach shared, patient-centered goals. As care coordinators, registered nurses can drive efficiency in the delivery system while ensuring the needs and preferences of patients are met. It is imperative that policymakers, health care organizations, and payers recognize and support the nurse's role in care coordination.

As the health care delivery system increasingly moves toward preventive health and wellness, care coordination models are becoming commonplace. For these models to be successful, incentives must be created to reward evidence-based practices and ensure the models include nurse-led and -supported interprofessional approaches, greater health system integration, and payment parity.

Previous Position Statements

ANA has created a series of resources over the years guiding ANA policy relevant to registered nurses' role in care coordination. This 2021 update, for the most part, retires an older, out-of-date statement while also updating those that remain relevant for policy purposes.

Retired statement:

- Care Coordination and Registered Nurses' Essential Role, June 2012.

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