Policy Agenda for Nurse-Led Care Coordination

AMERICAN NURSES ASSOCIATION

AMERICAN ACADEMY OF NURSING
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CONTENTS

REPORT DEVELOPED FROM:
Care Coordination Task Force

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I. Introduction and statement of policy priorities

The Care Coordination Task Force (CCTF) was convened in mid-2014 by the leadership of the American Nurses Association (ANA) and the American Academy of Nursing (AAN) to review major position papers and policy briefs on care coordination published between 2012 and 2013 by expert panels of both organizations, and to recommend specific and actionable federal policy priorities to advance nursing's contributions to effective care coordination. Nurses have been and continue to be pivotal in the development and delivery of innovative care coordination practice models. The 2011 Institute of Medicine Report on the Future of Nursing (Institute of Medicine, 2011) emphasized the nursing profession's long-term strength in improving the quality, access and value of health care through care coordination. The rapid changes transforming health care today and increased demand for care coordination require immediate action to enable nurses and other qualified health professionals to deliver outstanding care coordination to achieve the nation's quality agenda as outlined in its National Quality Strategy (NQS) (Agency for Healthcare Research and Quality [AHRQ], 2011). Recognizing this urgent need, ANA and AAN charged the CCTF with translating seminal documents crafted by their members into a blueprint for policy action.

Members of the CCTF prioritized policy recommendations to support and reduce barriers for nurses to practice the full scope of their care coordination expertise. They acknowledged that members of other professional and nonprofessional groups also are instrumental in the implementation of care coordination interventions. Their approach was to generate general overarching policy priorities that may be aligned with interprofessional colleagues with supporting short-term (within one year) and longer-term (within three years) strategies that maximize nursing's contributions.

The task force supports implementation of the following policy recommendations and short-term strategies to contribute to effective care coordination in traditional and community settings. Long-term strategies to support and advance the short-term strategies also are discussed.

Policy priorities

Policy priority #1: Payment should be expanded for consistency across all qualified health professionals delivering high-value care coordination activities, including bachelor's-prepared nurses.

Short-term strategy #1: Create provisions for payment of care coordination based on a set of common tasks delineating qualifying providers for payment and providing payment with supporting documentation.

Short-term strategy #2: Advocate for inclusion of team-based accountability and transparency.

Short-term strategy #3: Advocate for full scope of practice of advanced practice registered nurses (APRNs).

Short-term strategy #4: Identify bachelor's-prepared registered nurses (RNs) as qualified providers of care coordination services.

Policy priority #2: Accelerate the design, endorsement and use of rigorously tested care coordination measures, including those central to the domains of nurse care coordination.

Short-term strategy #1: Solicit promising care coordination measures from the nursing community.

Short-term strategy #2: Convene a national group to identify effective strategies to increase funding streams for the development and testing of care coordination measures central to the domains of nurse care coordination practice.

Short-term strategy #3: Refine and strengthen strategies to seat expert nurses on national care coordination measure development and review panels.

II.   **Background and guiding principles**

The CCTF was convened by ANA and AAN to prioritize policy options for advancing care coordination and to propose actionable strategies and leadership to advance their implementation. As an initial step in drafting policy recommendations, task force members reviewed seminal policy and position papers on care coordination prepared by AAN and ANA expert panels and work groups:

- The imperative for patient-, family- and population-centered interprofessional approaches to care coordination and transitional care: a policy brief by the American Academy of Nursing's CCTF, Nursing Outlook 60 (2012), 330-333. (P. Cipriano, 2012).

- The importance of health information technology in care coordination and transition care, Nursing Outlook 61 (2013), 475-479. (P. F. Cipriano et al., 2013).

- The value of nurse care coordination: a white paper of the ANA, Nursing Outlook 61 (2013), 490-501. (Camicia et al., 2013).

- Framework for measuring nurses' contributions to care coordination, ANA Care Coordination Quality Measures Professional Issues Panel, October 2013.

Following review of these papers, CCTF members gathered information about recent developments in care coordination practice, measurement and payment. With the assistance of project staff, they generated a comprehensive list of potential priority areas for advancing care

coordination, including payment for all qualified health professionals, payment for team-based care, performance measurement, health information technology, development and expansion of best practice models, workforce development, common definitions and service scope, outcome research, incentives for patient and family engagement, and standardization of competencies for accreditation and maintenance of certification.
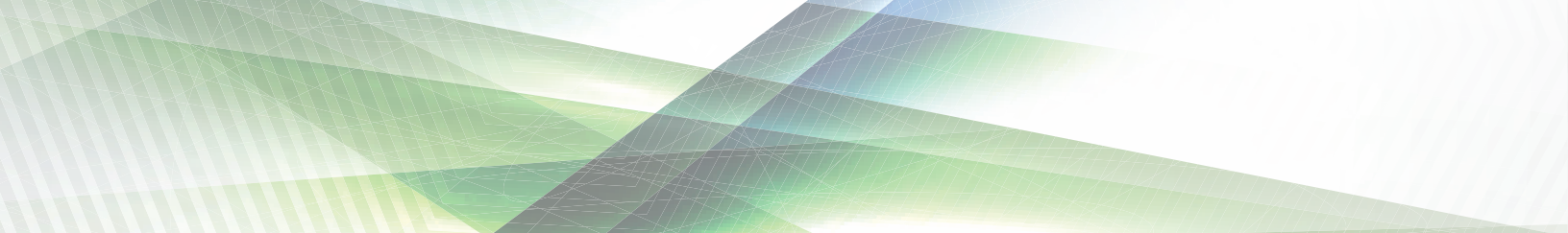
Task force members then ranked these areas according to importance for advancing care coordination practice and its outcomes, alignment with current and pending policies relevant to care coordination, and feasibility of short-term success in policy change and funding. They reached a consensus on two key priority areas on which to initially focus their policy recommendations: (1) expanding payment at an equitable and consistent rate for care coordination provided by all qualified health professionals; and (2) developing, implementing and evaluating performance measures to accelerate high-value care coordination provided by the United States health care system.

Members of the task force believe that these two priority areas are consistent with recommendations from ANA and AAN position papers and are core to advancing the quality of care coordination practice and outcomes by nurses and other qualified health professionals. While the policy recommendations for care coordination payment and performance measurement are presented separately, task force members viewed them as highly interdependent and supported by evidence, much of which emanates from high-value care coordination models provided by nurses that have been developed, implemented and evaluated for decades (see Figure 1).

Figure 1: Task Force Framework for Care Coordination Policy Recommendations

As a first step, the CCTF members established guiding principles in which to situate their policy recommendations. They emphasized the importance of removing barriers to effective care coordination by supporting APRNs and RNs in their ability to practice to the full extent of their education and training. The ability to accurately attribute the unique contributions of nurses working independently or as members of a team was viewed as central to professional practice and all policy recommendations. Without linkages to attribution, nursing's contributions are silent, and the ability to examine activities and interventions of the nurse is limited. The value of nursing interventions on patient health must be examined and known to promote transparent accountability and advance both payment and performance measurement.

Drawing from the work of the ANA panel, the CCTF identified additional principles that ground their policy recommendations: accessible (i.e., that payment optimizes access to care), equitable, rational, evidence-based, patient-/family-centered, interprofessional, inclusive, accountable and efficient (or resourceful). Some members cited the need for comprehensible rules and transparency in public reporting of data regarding care coordination outcomes to enhance consumer selection of higher-value health care.

III.   Policy priority #1: Payment should be expanded for consistency across all qualified health professionals delivering high-value care coordination activities, including bachelor's-prepared nurses.

Reimbursement to all qualified health professionals who deliver care coordination services is needed to promote high-quality/value care coordination and facilitate patient choice to better achieve patient-/family-centered outcomes. Payment has the best opportunity to stimulate value when constrained only by performance expectations. Payment should be directed to the highest-performing care coordination practice — regardless of which health care professional provides these services. Evidence suggests nurse-led care coordination or team-based models in which nurses play a central role are effective. Nurses will then need to emphasize the knowledge and skills they bring to care coordination, as will all eligible health professionals.

Expanding payment to all qualified professionals will actualize an interprofessional health care workforce in which the health professional most qualified to deliver the highest-performing care coordination practice to meet the needs of patients/families delivers care coordination services for people with complex and chronic conditions. These services are often needed in challenging settings, working with vulnerable populations in which nurses often lead care coordination teams. While our recommendation starts with payment for all qualified health professionals, development of a long-term payment strategy for team-based accountability is in order. We should support value-based purchasing that promotes flexibility in how payment is made and enables nurses to receive payment for high-quality, efficient care coordination.

The first policy strategy focused on payment is viewed as urgent and foundational to advance nursing's contributions to effective care coordination. As noted previously, nurses serve a central role in diverse models of care coordination for people with complex illnesses across health care settings, demonstrating impressive health care quality and lower costs (Camicia et al., 2013). Yet most of the current and proposed payment models focus on physicians and APRNs and do not recognize the significant contributions of bachelor's-prepared RNs or the efforts of other health professionals who contribute to care coordination as members of interprofessional teams.

Currently, there are a few initiatives and pieces of legislation that may offer an opportunity to introduce payment for all qualified health professionals. The Department of Health and Human Services recently announced that it will be creating a Health Care Payment Learning and Action Network (Centers for Medicare and Medicaid Services [CMS], n.d.) to spread value-based payment models, which may provide a venue to test innovative care coordination models nationally. Additionally, CMS proposed changes to the payment policy under the Physician Fee Schedule for chronic care management (CCM) (Department of Health and Human Services, 2014). Coordination of care services that are non-face-to-face will be reimbursed for Medicare beneficiaries with two or more chronic conditions expected to last at least 12 months. APRNs will be eligible for reimbursement, but, as yet, non-APRN nurses working to the full scope of their education, training and licenses, and other health professionals beyond physicians, will not.

Policy priority #1: Short-term strategies

Four short-term strategies are priorities for achieving policy priority #1. These strategies are aimed at specifying performance expectations for care coordination and recognizing and measuring contributions of all qualified health professionals who contribute to care coordination individually and as members of an interprofessional team.

Short-term strategy #1: Create provisions for payment of care coordination based on a set of common tasks delineating qualifying providers for payment and providing payment with supporting documentation.

Specification of high-value care coordination activities is central to payment policy. While this work is underway and represented in ANA and AAN documents reviewed by the task force, it is not complete and demands immediate attention.

ANA and AAN should appoint a task force to identify professional organizations that represent providers that may be eligible for reimbursement for care coordination; develop a taxonomy of structures, processes and outcomes for care coordination; and work with CMS to advocate for a common taxonomy and to harmonize definitions for use in measure development and evaluation. The taxonomy should be matched to RN and APRN tasks as qualified providers.

Short-term strategy #2: Advocate for inclusion of team-based accountability and transparency.

Emerging delivery models including accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) rely on effective teamwork and collaboration to ensure professional practice at full scope and achievement of NQS priorities, including care coordination. Current payment models do not recognize the high-value care coordination activities provided by health professionals other than those identified as qualified providers. Along with clear specification of high-value care coordination activities, paving the way for equitable payment for care coordination requires advocating and developing the infrastructure for:

- Team-based accountability for high-value care coordination: Providers must recognize that care coordination activities require contributions of team members best-prepared to carry out these activities.

- Transparency: National Provider Identifier data should be collected for all team members and include bachelor's-prepared RNs and APRNs to ensure attribution and commensurate payment. Transparency related to care coordination activities is needed to determine the optimal mix of clinicians with the right staffing/skill mix to yield the best outcomes for specific populations at risk.

ANA should take the lead on developing and implementing advocacy tactics for team-based accountability and transparency and should partner with ANA organizational constituencies and affiliates, including AAN expert panels, specialty nursing organizations and other stakeholders.

Short-term strategy #3: Advocate for full scope of practice of APRNs.

Current care coordination payment models include provisions for APRN payment. Short-term strategy #3 is aimed at better positioning APRNs to lead and influence the development, implementation and evaluation of high-value care coordination models. To date, a few APRNs have successfully formed PCMHs. Their impact on care coordination activities and relevant outcomes in these settings should be closely monitored.

In addition, strategies should be undertaken to include APRNs at the highest levels of other emerging practice models, such as ACOs. There is a shortage of primary care providers limiting access to care for vulnerable populations to the right care, at the right time, with the right clinician team (e.g., timely palliative/end-of-life care, chronic care, etc.). Lack of timely access reduces patient-/family-centered care and increases cost due to avoidable adverse events (e.g., avoidable emergency department admissions and readmissions).

ANA and AAN should advocate to have the final rule amended to authorize APRNs as eligible providers to certify plans of care across all care settings, prioritizing post-acute care/long-term care settings (specifically home health care, nursing homes, assisted living and skilled nursing facilities) as a beginning to improve patient-centered care outcomes (e.g., reduce rehospitalization). ANA and AAN should identify organizations that are already working on authorizing APRNs to certify plans of care across all care settings, prioritizing post-acute care/long-term care settings.

Short-term strategy #4: Identify bachelor's-prepared RNs as qualified providers of care coordination services.

Bachelor's-prepared nurses have led and contributed to care coordination models for decades. Care coordination is an essential competency for all bachelor's-prepared nurses (American Association of Colleges of Nursing, 2008; American Nurses Association, 2010). Bachelor's-prepared nurses have the education and experience to (1) direct care coordination across settings and among caregivers, including oversight of licensed and unlicensed personnel in any assigned or delegated task; and (2) partner with other clinicians and caregivers in interdisciplinary teams to promote positive patient outcomes (American Nurses Association, 2010). Yet their care coordination activities are not recognized or included in any current or proposed payment model. For the most part, high-value care coordination activities delivered by bachelor's-prepared nurses are attributed and paid to professionals currently designated as qualified providers.

ANA should advocate for bachelor's-prepared nurses to practice to the full extent of their education and experience, and for their designation as qualified providers; their payment should not be rolled into payment for other providers (similar to being included in bed-and-board in hospitals). ANA's regulatory team should work with constituencies to ensure that final rules include team-based accountability, transparency and appropriate health professionals (including bachelor's-prepared nurses) in the reimbursement for CCM.

Longer-term considerations

Task force members identified several longer-term initiatives to support and advance achievement and maintenance of the short-term payment priorities.

• Monitor and evaluate the transition from fee-for-service to capitation, and optimize the benefits of capitation to support care coordination.

Evaluation will be of primary importance as commons sets of tasks are identified (short-term strategy #1), team-based accountability is enhanced (short-term strategy #2), and APRNs' and bachelor's-prepared nurses' full scope of practice is realized (short-term strategies #3 and #4). As capitated payment for care coordination is implemented, ANA and AAN should evaluate the impact of changing reimbursement on economic and patient outcomes. They should advocate for per member per month models, which are capitated models of reimbursement, as they will reduce clinician burden for billing (e.g., CPT codes for CCM) and reduce the opportunity for gaming.

• Support and advocate for testing of innovative nurse-led and interprofessional high-value care coordination models.

There is mixed evidence supporting various models of care coordination. The Community-based Care Transitions Program funded by CMS evaluation is still underway. A generation of new, innovative models of care coordination that are both nurse-led and interprofessional is needed. For example, research indicates that family members recognize the need and take responsibility for many care coordination activities. Consumer-driven models of care to pay for needed care coordination services and to reimburse family members and significant others for high-value care coordination activities will likely involve APRNs and bachelor's-prepared nurses in care coordination services. Funders will need to commit to a program of research to test the efficacy and effectiveness of these new models of care.

ANA and AAN should work with CMS to advocate for testing care coordination interventions in all relevant Center for Medicare and Medicaid Innovation (CMMI) initiatives, including the Bundled Payments for Care Improvement initiative. They also should work with AHRQ and the Patient-Centered Outcomes Research Institute (PCORI) to encourage funding for multisite cluster trials of nurse-led care coordination interventions, including those with consumer-driven options.

IV. **Policy priority #2: Accelerate the design, endorsement and use of rigorously tested care coordination measures, including those central to the domains of nurse care coordination.**

The importance of robust measures of care coordination practice was highlighted in each of the foundational papers reviewed by members of the CCTF. AAN's policy briefs on patient-, family- and population-centered interprofessional approaches to care coordination and transitional care and health information technology recommended immediate policy action to "expedite funding to develop, implement and evaluate performance measures that address gaps in effective and efficient care coordination" (P. Cipriano, 2012) and harmonize data elements and standards
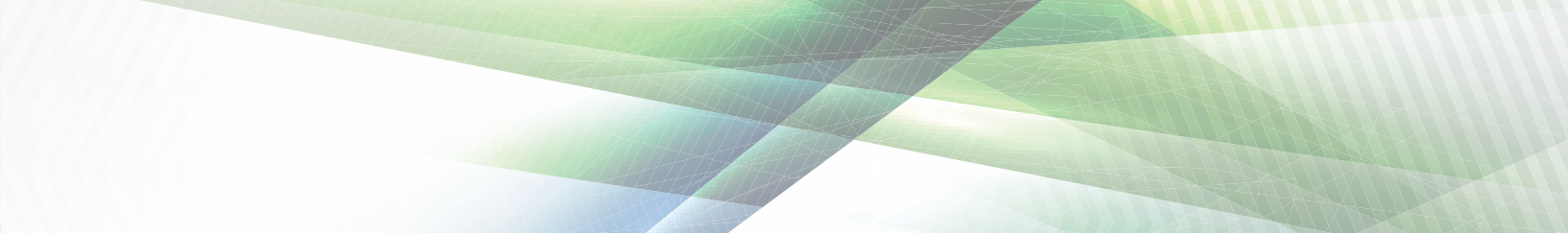
requirements for a single patient-centered, consensus-based, longitudinal plan of care that is interoperable and accessible to patients, families and all providers across all settings (P. F. Cipriano et al., 2013). ANA's white paper on the value of nurse care coordination and its framework for measuring nurses' contributions to care coordination specified principles to guide measurement development, including transparency, parsimony, evidence-based, comprehensiveness and interprofessional teamwork, as well as measurement domains associated with effective nurse care coordination practice.

In the short period since these papers were published and widely disseminated, there have been a few promising advances in care coordination performance measurement. In 2013, as part of its reorganization, NQF established a standing committee on care coordination performance measures with a nurse as co-chair. NQF also convened a new work group to address measurement gaps in care coordination. This work group proposed a new definition of "care coordination" to guide measure development and revisions to the 2006 NQF measurement domains, thereby bringing them into close alignment with the goals and strategies of the national quality agenda (Table 1). The ANA framework for performance measurement of care coordination was one of the source documents used to inform these changes.

Table 1: Changes in NQF's Care Coordination Definition and Measurement Domains, 2006 and 2014

Topic	2006	2014
Definition of "care coordination"	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.	The deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for health care and community services are met over time.
Measurement domains	• Health care home. • Proactive plan of care and follow-up. • Communication. • Information systems. • Transitions or handoffs.	• Joint creation of a patient-centered plan of care. • Use of a health neighborhood to execute plan of care. • Achievement of outcomes.

Sources: National Quality Forum, 2006; National Quality Forum, 2014b

In addition to these definition and framework refinements, CMS, AHRQ and the National Committee for Quality Assurance (NCQA) have embarked on funded initiatives to develop new care coordination measures. CMS has been a significant leader in closing the measures gap through its Measure Management System Blueprint. AHRQ has funded the American Institutes for Research to develop a new Care Coordination Quality Measure for Primary Care as part of its Care Coordination Measures Development Phase III program. NCQA is currently convening work groups to develop new care coordination measures for Medicare Advantage Plans. PCORI has an interest in health system interventions and has funded a major national study to investigate which transitional care services are most effective in improving patient-centered outcomes. Results will provide evidence supporting structure and process measures for care coordination.

Although the launch of each of these initiatives suggests greater interest in developing a robust set of care coordination measures that reflect changes in health care and evolving care coordination practice models, there is still a paucity of endorsed care coordination performance measures. Only one new care coordination measure was submitted to NQF for endorsement in the previous two review cycles. Most of the currently endorsed measures are setting- or "eligible provider"-specific and are limited to a very small set of the refined NQF measurement domains. Measure development activities convened by AHRQ, and NCQA are in the very early stages. Most existing measures are low-level (e.g., check box) process measures. The right mix of high-impact structure, process and outcome measures is needed. Patient-reported outcomes also are needed.

While there is considerable discussion of the shortcomings of the current care coordination measurement set, there also is recognition that development and testing of new measures are expensive and time-consuming, with few sources of funding. In addition, the feasibility of capturing data for more robust measures is a challenge. Significant gaps remain in domains of care coordination integral to nurse care coordination practice, including shared decision-making in the patient-/family-centered plan of care, shared accountability among team members for the plan of care, timeliness and accountability of services, care recipient and family experience of care coordination, and impact on quality outcomes and costs of care.

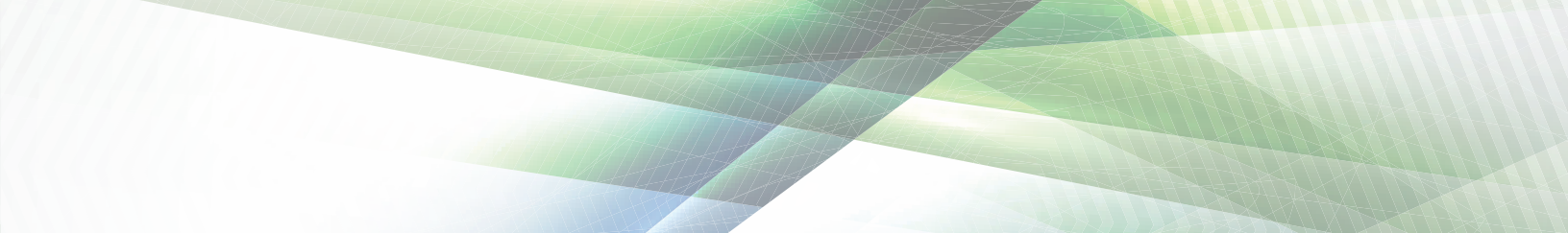## Setting the stage for performance measurement policy strategies

Task force members identified several issues affecting the current context and political environment for policy recommendations and strategies related to advancing care coordination performance measurement.

Definition of "care coordination": Definitions of "care coordination" driving performance measurement continue to evolve. Different definitions are being used to guide measure review, endorsement and regulation. The CCTF reviewed the variety of definitions available and evaluated their alignment with domains proposed in the ANA's Framework for Measuring Nurses' Contributions to Care Coordination (ANA Care Coordination Quality Measures Professional Issues Panel, 2013). Recognizing that the ANA framework informed NQF's most recent changes to its care coordination definition and domains, the task force members proposed that their policy recommendations build on the 2014 NQF consensus definition and highlight key aspects central to nursing in the development of the care coordination measurement set. Task force members affirmed the importance of patient-/family-centeredness, patient engagement, integration of care, the full continuum of care and payment in NQF's definition and measurement domains, and recommended that each of these elements be made more explicit in future revisions. Policy strategies for advancing care coordination performance measurement must be guided by a strong patient-centric model that emphasizes patient and family engagement and collaboration with providers across the care continuum of care planning and evaluation. There needs to be an emphasis on the human interaction that is foundational to effective care coordination intervention as well as the workflow and sequencing components included in the definition.

Priority measures: The current set of care coordination performance measures has significant gaps in areas that are central to nurse care coordination practice and to core competency areas required for payment to all qualified health professionals. Immediate priorities for filling these gaps identified by task force members include:

- As feasible, a harmonized set of care coordination measures across the full continuum of care, including primary care, acute care, post-acute and long-term care, hospice, assisted living, and community services.
- Screening and risk assessment measures that capture evidence-based risk assessment at each point of care.
- Implementation of endorsed medication reconciliation measures.
- Advanced care planning.
- Patient engagement competencies for care coordination and transitional care.

eMeasures: As recommended in the AAN paper on health information technology, the development of care coordination measures needs to anticipate requirements for eMeasures that support standards and interoperability and accessibility to patient-/family-centered care coordination data.
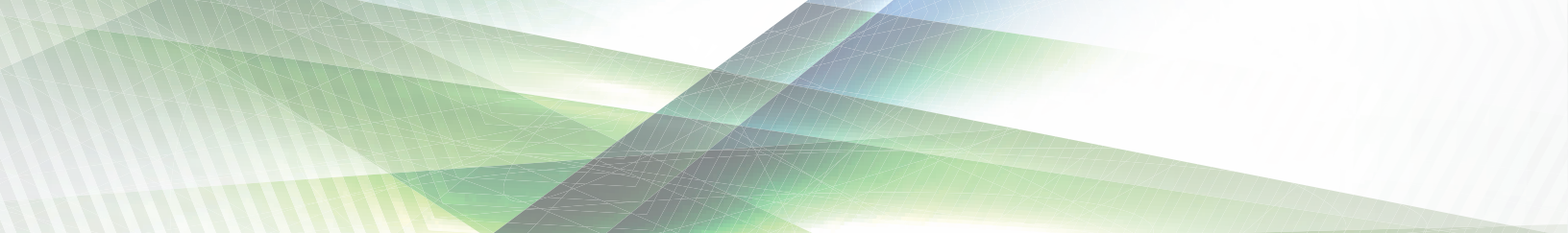
Team-based care coordination measures: Care coordination is commonly defined and operationalized in the context of interprofessional teamwork, shared accountability and collaboration. The processes of care coordination require expert integration and synchronization between and among patients, families, professional and lay providers, and health care and community settings, as reflected in current definitions and frameworks. Translating shared accountability and determining attribution of care coordination to the individuals and groups that have the requisite competencies and actually do the work are significant issues and tension points in the care coordination payment dialogue. The members of the CCTF support team-based measures for care coordination in philosophy; they believe that considerably more analysis and discussion are required before team-based measures are proposed as a policy priority.

Policy priority #2: Accelerate the design, endorsement and use of rigorously tested care coordination measures, including those central to the domains of nurse care coordination.

Three short-term strategies are priorities for achieving policy priority #2. These strategies are aimed at creating a wider pool of potential care coordination measures from nurses in practice, generating funding for measure development and testing, and positioning nurses on key committees guiding selection of care coordination performance measures.

Short-term strategy #1: Solicit promising care coordination measures from the nursing community.

There is no question that nurses are leading and participating in the development and refinement of care coordination models in all practice settings. Examples of the range of nurse-led models for patient-centered medical homes, post-acute and long-term care, and transitional care are evident in published literature as well as the numerous conferences on care coordination, continuity of care, care across the continuum and other related topics. Many of the preferred practices that are used to guide development and support NQF's care coordination performance measures derive from programs and models developed by nurses in which nurses lead and provide the majority of the care coordination interventions in multiple roles. It is likely that many nurse care coordination programs are using homegrown and/or standardized performance measures to capture structures, processes and outcomes of care coordination. Few, if any, of these measures are being developed to meet rigorous endorsement criteria. Since only one new care coordination measure was submitted for NQF review in the previous two review cycles, it is questionable whether nurses are aware of the need and opportunity to develop nascent measures or the process needed to submit them for endorsement.

Nurse-developed and -led care coordination programs may be a rich and untapped source of measures to fill the care coordination measurement gap, particularly in the domains of care coordination most reflective of nursing interventions and contributions to care coordination. As a first step in moving toward performance metrics, the state of development of care coordination measures should be established. Measures should capture the actual practice work of care coordination and can be used to define competencies and payment for all qualified health professionals. The task force recommends that ANA and AAN develop a working group with the Nursing Alliance for Quality Care (NAQC) and membership from all nursing specialty groups to conduct a national campaign to solicit care coordination measures being used in nurse care coordination programs. ANA, AAN and nursing specialty organizations should survey research-intensive members (including AAN Edge Runners) to determine if care coordination measures have been developed and used within nurse-scientist-conducted research studies.

Short-term strategy #2: **Convene a national group to identify effective strategies to increase funding streams for the development and testing of care coordination measures central to the domains of nurse care coordination practice.**

Growth of the care coordination measurement set is severely limited by the lack of funding for measure development and testing. The few measure development initiatives currently funded are targeted to specific practice settings (e.g., primary care), eligible providers and/or specific populations (Medicare Advantage members). Expanding funding streams for measure development and testing is essential to improve the state of performance measurement for care coordination.

The CCTF recommends that ANA and AAN convene a national task force with the major funders of care coordination measure development and testing, including CMS, AHRQ and major organizations influencing the selection and endorsement of care coordination measures used for payment guidelines, such as NCQA, the Measurement Application Partnership (National Quality Forum, 2014a) and NQF, to review measurement gaps in care coordination and propose initiatives to fund development and testing of care coordination measures that align with core nursing domains and achievement of the national quality agenda goals.

Short-term strategy #3: Refine and strengthen strategies to seat expert nurses on national care coordination measure development and review panels.

Key decisions about development, evaluation and selection of measures for national payment programs like value-based purchasing are initiated and influenced within expert panels, task forces and standing committees. The nursing community has made tremendous strides in the past several years in seating nurse experts on care coordination on committees at CMS, AHRQ and NQF.

The CCTF recommends that ANA and AAN convene a task force to review and strengthen current processes to identify and place nurse experts on care coordination performance measurement committees in order to increase the number of nurses on these committees and to prepare for succession planning.

Longer-term consideration

- Evaluate the value and feasibility of team-based care coordination measures.

As already discussed, CCTF members acknowledged potential advantages of team-based measures for capturing the actual delivery of care coordination services and addressing accountability and attribution issues. The current state of team performance measurement is not well-developed, and there is no consensus about how these measures may be feasibly operationalized or implemented within payment policy. The CCTF recommends further analysis of the value and feasibility of these measures.

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Summary of Care Coordination Policy Priorities, Short-Term Strategies and Longer-Term Considerations

Care coordination policy	Strategies	Lead organizations
Payment	Short-term strategies	
Payment should be expanded for consistency across all qualified health professionals delivering high-value care coordination activities, including bachelor's-prepared nurses.	1. Create provisions for payment of care coordination based on a set of common tasks delineating qualifying providers for payment and providing payment with supporting documentation. 2. Advocate for inclusion of team-based accountability and transparency.	ANA and AAN should appoint a task force in the private sector to develop the taxonomy of common tasks, match tasks to qualified providers (RNs and APRNs), and advise CMS and other payers on evidence from research. Representatives from CMS, AHRQ, PCORI and other payers may be invited to participate in the task force.
		ANA should take the lead on developing and implementing advocacy tactics for team-based accountability and transparency, and partner with ANA organizational constituencies (organizational affiliates and other specialty nursing organizations, such as geriatric nursing groups and AAN expert panels) and other stakeholders (e.g., payers, consumers as buy-in is solidified).
	3. Advocate for full scope of practice of APRNs. Specifically, ANA and AAN should advocate to have the final rule amended to authorize APRNs as eligible providers to certify plans of care across all care settings, prioritizing post-acute care/long-term care settings (specifically home health care, nursing homes, and assisted living and skilled nursing facilities) as a beginning to improve patient-centered care outcomes (e.g., reduce rehospitalization).	ANA and AAN should identify organizations that are already working on this (there is proposed legislation with bipartisan support). Begin with Robert Wood Johnson Foundation, AARP (Campaign for Action) and Johnson & Johnson.

Care coordination policy	Strategies	Lead organizations
Payment	Short-term strategies	
	4. Identify bachelor's-prepared RNs as qualified providers of care coordination services.	ANA and AAN should employ multiple strategies, resources, levers and constituencies. Consumers Union may be a potential partner.
	Longer-term considerations	
	1. Monitor and evaluate the transition from fee-for-service to capitation, and optimize the benefits of capitation to support care coordination.	ANA and AAN should evaluate the impact of changing reimbursement on economic and patient outcomes.
	2. Support and advocate for testing of innovative nurse-led and interprofessional high-value care coordination models.	ANA and AAN should work with CMS to advocate for testing care coordination interventions in all relevant CMMI initiatives, including the Bundled Payments for Care Improvement initiative. They also should work with AHRQ and PCORI to encourage funding for multisite cluster trials of nurse-led care coordination interventions.
Performance measurement	Short-term strategies	
Accelerate the design, endorsement and use of rigorously tested care coordination measures, including those central to the domains of nurse care coordination.	1. Solicit promising care coordination measures from the nursing community.	ANA, AAN, NAQC and nursing specialty organizations should determine the state of development of care coordination measures. A survey of research-intensive members, including AAN Edge Runners, should be conducted to determine if care coordination measures have been developed and used within nurse-scientist-conducted research studies.
	2. Convene a national group to identify effective strategies to increase funding streams for the development and testing of care coordination measures central to the domains of nursing care coordination practice.	ANA and Academy to work with CMS, AHRQ, NQF, NCQA, Office of the Assistant Secretary for Health, key stakeholder groups, e.g., consumers and other purchasers; Start with CMS
	3. Refine and strengthen strategies to seat expert nurses on national care coordination measure development and review panels.	ANA, Academy, and NAQC to convene a working group to review current procedures and processes and propose strategies for timely appointments.
	Longer-term consideration	
	1. Evaluate the value and feasibility of team-based care coordination measures.	The AAN expert panel should work with CMS and the Physician Consortium for Performance Improvement.

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