Care Coordination: *Using the Present to Transform the Future*

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The current legislative, financial, and technology environments have strongly positioned nursing to expand its leadership role in care coordination and to extend it far into the future. The Affordable Care Act (ACA) provides policy support as nurses continue to incorporate care coordination into their practices. This article reviews how nurses have taken advantage of those policy changes to shape, and in turn lead, care coordination efforts into the health care environment's future.

CARE COORDINATION: THE PAST

Care coordination is an essential component of patient care management, especially for at-risk and vulnerable populations. For the Agency for Healthcare Research and Quality (AHRQ), care coordination is defined 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. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."[1] The National Quality Forum (NQF) outlines a similar description, "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."[2]

Nurses have provided care coordination for decades. The 1980s introduced the diagnosis-related group (DRG) (or case-based) reimbursement system to Medicare, most hospital's major payer source. In addition, there was tremendous growth in managed care in the 1980s and 1990s. Success in the restructured financial world mandated the development of new approaches to managing patient care and related costs. In the payer world, health plans established primary care gatekeepers to increase management of member access to specialists. Health plans also deployed utilization managers to perform utilization review and coordinate post hospital care for their members. Strategies for better management of patient care within hospitals was also essential.

Case management evolved as a strategy for hospitals to strategically manage clinical outcomes and length of stay, particularly as DRGs were introduced. The Center for Case Management (CCM) was established in 1986 at New England Medical Center (now Tufts Medical Center, Boston, Massachusetts) and transitioned into an independent, nurse-owned company in 1989. In partnership with Medical Center colleagues, co-owners, Kathleen Bower, DNSc, RN, FAAN, and Karen Zander, MS, RN, FAAN, CMAC, created the framework for hospital-based case management. The invention of Clinical Paths/CareMap tools provided an additional approach to care coordination, particularly focused on more predictable patient populations. Both case management and Clinical Paths demonstrated reductions in length of stay while maintaining or improving patient outcomes. CCM responded to requests from hospitals nationally and internationally to improve their management of patient care.

Almost simultaneously, in the late 1980s, Carondelet St. Mary's Hospital (Tucson, Arizona) created one of the first community case management programs in the country. The goal was to improve the self-management abilities of patients/families and reduce the experience of readmissions. Community nurse case managers followed high risk patients into their homes post-hospitalization to provide education and coaching. Most of the patients had multiple chronic illnesses (including behavioral health) and inadequate support systems. Many were ineligible for home health or other post-acute services. Community nurse case management demonstrated significant overall reduction in health care costs and readmissions for its patients. Because of its successful experience in working with a capitated health plan, the Carondelet Model became 1 of 4 community nursing organizations to be funded by Medicare in the late 1990s.[3]

These successful care coordination models were adopted by many hospital systems and health plans. They created a structure and infrastructure to ground care coordination as it evolved. This was particularly important as risk sharing between plans, health systems, and physicians emerged. Care coordination became a critical element in contract negotiations. Nursing was at the heart of over 2 decades of creating structured and successful care coordination models.

TODAY'S LANDSCAPE

The ACA provides a great opportunity for nurses to have an impact on the health care environment, particularly in transforming from an "illness-focused" system to a true "health care" system.[4] The American Nurses Association identified several health reform provisions where nursing is the key to success. Some examples are provided below:

- A number of workforce policy initiatives are underway that will provide funding for nursing education to recruit new nurses and provide career advancements. For example, advanced nursing education grants through Health Resources and Services Administration offer federal funding to Universities to create partnerships with health care providers. The goals to increase the number of advanced practice nurses trained to practice in rural and other vulnerable community settings. These grants educate advanced practice nurses to work in patient-centric integrated delivery models with an emphasis on clinical and quality outcomes.[4]
- Federally qualified health centers provide services to millions of people in underserved urban and rural communities with limited access to health care. These centers are part of the fabric of change in the prospective payment system with nurse practitioners, certified nurse midwives, nurse care coordinators and nurse wellness coaches playing major roles in improving care and reducing costs.[5]
- Accountable care organizations (ACOs): "The Accountable Care Organization ACO is a group of providers and suppliers of services (e.g., hospitals, providers and others involved in patient care working together to coordinate care for their Medicare beneficiaries (excluding Medicare Advantage Plans)." ACA Section 3022 (p 277).[6] The nursing opportunities within an ACO structure include nurse practitioners, transitional care nurses for high risk populations, wellness coaches, and quality improvement specialists.

Although the ACA landscape provides countless opportunities for nurses to expand their footprints in the health care environment, it is important for nursing to own and assume leadership in the expansion of care coordination.

The American Nurses Association and the America Academy of Nursing's joint Care Coordination Task Force (CCTF) pub-