Position Statement on Care Coordination and Registered Nurses

The IOM Future of Nursing Report establishes the role of Care Coordinator, which is also known as Nurse Navigator, Case Manager and Health Coach, as a priority for Registered Nurses. “Coordinating care is one of the essential competencies of the nursing profession across the entire patient care population”. (IOM, 2010, p. 2-13)

Care Coordination unites a team of health care professionals to meet individual patient needs, improve health care access and outcomes, and synchronize care with a multitude of long-term services with the goal of cost effective mobilization and utilization of health care resources (ARHQ ,2010). The care coordinator works closely with the patient, family, caregiver, primary care provider, and other health care professionals to enhance communication, resulting in improved patient well-being and outcomes.

Therefore, it is the position of the Oklahoma Nurses Association that care coordination is a component of professional nursing practice, and only Registered Nurses should utilize the title of Care Coordinator. Licensed and unlicensed non-RN health care workers who lack the skill set to address the needs of patients with complicated health issues should not describe their jobs as care coordinators nor use the title Care Coordinator.

Background:

It is well known that the American health care system is already incredibly complex and will continue to increase in complexity due to advances in technology and the passage of the Affordable Care Act (ACA) which emphasizes high quality care, greater access to care, and improved outcomes at all points in the healthcare system. Effective coordination of care, in the management of chronic health conditions, have been shown to prevent deterioration and acute exacerbations that result in emergency room visits, hospitalizations, physical and emotional complications, and a marked decline in health status.

Care coordination programs with positive, rigorously evaluated and broadly replicable results require an initial comprehensive physical and psychosocial assessment and the development of a comprehensive patient centered evidence-based care management plan with services such as clinical decision making, patient self-care education, and coordination with a health care team that includes community-based services. Registered Nurses are essential to implementing chronic care models within a person-centered health care team (Bodenheimer & MacGregor, 2005); The Registered Nurse coordinator acts as the pivot point that connects providers, the health care team, the family and the patient so that everyone is actively engaged in the care process.

The Registered Nurse Care Coordinator provides patients with a single individual to contact who is accountable for their recovery. Although some health care facilities have recently placed non-Registered Nurses in positions of care coordinators, Registered Nurses are uniquely qualified for the role of care coordinator because of their broad based health care education, understanding of complex disease processes and leadership/management training.

The practice of registered nurses is central to coordinating the patient's health care experiences with the goal of improving health care quality, increasing access to care, and enhancing patient care and value perceptions of care (IOM, 2010). The Institute of Medicine (IOM) has concluded, "nurses… need to adopt reconceptualized roles as care coordinators, health coaches, navigators, and system innovators".

The American Nurses Association recognizes and promotes the integral role of registered nurses in the care coordination process to improve patient care quality and outcomes, and to decrease costs across patient populations and health care settings (ANA, 2012).

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