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Joint Statement: The Role of the Nurse Leader in Care Coordination and Transition Management across the Health Care Continuum

As health care's rapid pace of change continues, it is imperative that new models of care incorporate a broad understanding of care coordination and transition management across the continuum. Nurses are well positioned to coordinate and deliver these services to patients.

Care coordination and transition management roles are needed to support achievement of the Triple Aim: improving quality of care to individuals, improving the health of communities and simultaneously reducing costs. Comprehensive strategies are needed to assure patients and families experience seamless care provided by interprofessional care teams across health care settings. Strong leadership is needed to strategically drive innovation and inspire transformative change in a complex health care environment. The role of the nurse leader is to advocate the value of nursing in care coordination and transition management.

The American Organization of Nurse Executives and the American Academy of Ambulatory Care Nursing collaborated to outline how nurse leaders in inpatient and post-acute/outpatient settings should approach their roles to enhance development of care coordination and transition management across the continuum of care. Nurse leaders can activate interprofessional collaboration through adoption and engagement in the following strategies. These six principles provide a basis for establishing an informed and collaborative care coordination process that includes all staff, key stakeholders and nurse leaders across the continuum of care.

1. Know how care is coordinated in your setting.

- Know your population. What are their needs, requirements and resources?
- Identify, track and simulate the patient's journey through the health care system.
- Know and understand your current patient transition infrastructure and how the team of interprofessional leaders communicates.

2. Know who is providing care.

- Conduct an organizational assessment of individuals, specifically nurses, providing care coordination and transition management activities. What are their roles, competencies, preparation and training?
- Develop role definitions, including key job responsibilities, for each member of the interprofessional care team across the continuum of care that are evidenced-based and organization appropriate.

3. Establish relationships with multiple entities and individuals who can work together to improve care coordination and transition management systems.

- Identify leaders across the continuum involved in or impacted by care coordination activities and create a shared vision.

- Convene an internal interprofessional stakeholder group of team members involved with care coordination across the continuum of care. Invite external stakeholders to join the group based on the needs of your particular hospital and post-acute care/outpatient settings.
 - Invite all stakeholders to provide input on aligning communication and collaboration between current resources to improve care coordination and transition management.
- 4. Know the value of technology, its impact on workflow and the roles of care coordination team members.**
- Assess the current state of technology as it impacts care coordination and patient transitions of care.
 - Strategize and optimize potential technology, workflow and role development to support seamless care coordination for the future. Identify the gaps between the current and desired future state.
 - Work with information technology staff on data analytics to capture outcomes and identify high risk patients in need of care coordination and transition management.
- 5. Engage the patient and family.**
- Determine how patients and families want to be involved in coordination of their care. Utilize patient engagement strategies to assess and activate patient and family involvement in care.
 - Ensure all staff members are competent in engaging the patient and family in care coordination.
 - Engage the patient and family in developing and understanding the plan of care (i.e. who will deliver the care, when and what is their role in the care process).
 - Provide the patient and family with a point of contact (a specific person or 24-hour support line) to address needs.
 - Develop workflows to include patients and families on advisory boards, in survey development and review of survey results, and shared decision-making for overall care coordination process improvement.
- 6. Engage all team members in care coordination.**
- Select a nurse leader and a physician leader (e.g. CNO and CMO or chief of staff) to co-lead care coordination efforts.
 - Identify physician partners to co-lead care coordination and transition management strategies and to influence staff physicians.
 - Educate leaders and staff about the value of care coordination and how it can achieve the health care system's goals of improving the patient experience, increase patient engagement in self-management and improve population health.

About the American Organization of Nurse Executives (AONE)

AONE is the national professional organization for nurses who design, facilitate and manage care. With more than 9,000 members, AONE is the leading voice of nursing leadership in health care. Since 1967, the organization has provided leadership, professional development, advocacy and research to advance nursing practice and patient care, promote nursing leadership excellence and shape public policy for health care. AONE is a subsidiary of the American Hospital Association. For additional information, visit the [AONE website](#).

About American Academy of Ambulatory Care Nursing (AAACN)

AAACN is the specialty nursing organization for registered nurses practicing in ambulatory care or outpatient settings. Founded in 1978, AAACN provides opportunities for over 3,000 members to advance their practice and leadership skills, enhance their professional growth and career advancement, and provide connections with others in similar roles. In fulfilling its mission to advance the art and science of the specialty, AAACN expands the influence of ambulatory care nurses as leaders of coordinated, cost-effective and quality patient care in the ambulatory setting. For additional information, visit the [AAACN website](#).

Resources:

[Care Coordination and Transition Management Core Curriculum](#)

Definitions of [care coordination](#) and [transition management](#)

[Role of the Registered Nurse in Ambulatory Care Position Statement](#)

[Telehealth Nursing Practice Toolkit](#)

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