AMERICAN ASSOCIATION OF
NURSE ASSESSMENT COORDINATION

Defining the Role of Nurse Assessment Coordinators: Beyond Paperwork and Reimbursement

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Introduction

The American Association of Nurse Assessment Coordination (AANAC) defines a nurse assessment coordinator (NAC) as the nurse who is accountable for coordinating and overseeing the full collaborative, interdisciplinary assessment and care planning process in skilled nursing facilities. This process includes comprehensive resident assessments; care coordination and planning; resident advocacy and teaching; facilitation of open communication among care team members, the resident, and family; collection and transmission of data for the purposes of quality improvement; and adherence to the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI) requirements. The ultimate goal of the assessment and care planning process is to promote the resident's quality of care and life in a skilled nursing facility, including individuality, safety, wellness, satisfaction, and dignity. The NAC is a champion of person-directed care and facilitates this through the assessment and care planning process.

The advent of the MDS version 3.0, health care reform, and an increased federal focus on cost containment have brought important new responsibilities for NACs and increased the complexity of their role. The NAC role and associated responsibilities influence the organization's financial health and community reputation, because the assessment responsibilities of the NAC determine an organization's case-mix reimbursement, Quality Indicator profile, and state surveyor focus. A well-educated and informed NAC with strong assessment and analytical skills, a thorough understanding of MDS 3.0 requirements, and a commitment to person-directed care is essential for a skilled nursing facility to survive in today's challenging, resource-stressed, competitive environment.

Evolution of the MDS and Nurse Assessment Coordinators

The passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA) changed the principles and expectations of nursing home quality assessment and required extensive federal changes to the criteria of nursing home regulations. This included a mandate for providing a resident assessment. The assessment was first launched in 1988 and was called the Minimum Data Set (MDS). It was designed to concentrate on the individual resident's functional, medical, mental, and psychosocial status (Institute of Medicine, 1987). OBRA did not, however, require the assessing nurse to evaluate quality of life. This was left to surveyors (Applebaum, 2009).

The first MDS lacked standardized assessment protocols for pain, incontinence, dementia, or mood. Assessment nurses used a variety of methods and measurement tools, which likely compromised the reliability of the data obtained (Applebaum, 2009). Overall, the MDS was created to gather data, but without a focus on how gathering that data would improve resident experiences. The Resident Assessment Protocols (RAPs) were designed in response to that concern, but, as with the first MDS, were not considered adequately reliable or valid because the RAPs did not utilize already well-established and standardized clinical tools (Applebaum, 2009).

The MDS has changed since the first version to include a greater focus on resident quality of life. It now offers improved and established assessment tools for pain, incontinence, cognitive status, and mood. The role of the NAC, which arose from the necessity to complete the MDS, has also changed and increased in complexity as a response to the need for better resident choice and improved Quality Measures. More in-depth assessments are guided by the newly added Care Area Assessments (CAAs) which replace the RAPs. The deeper focus on assessments is aimed at decreasing complications in long-term care residents and providing an improved quality of life. MDS 3.0, the newest version, requires the NAC not only to fulfill the data-gathering requirements present in the original MDS, but also to provide careful and thorough physical and psychological nursing assessments on each resident identified as at risk

during the completion of the MDS and CAAs. The NAC is responsible for communicating with the entire health care team to ensure provision of a cohesive and effective care plan. The NAC must also properly record the data in the database and transmit it to the appropriate location for payment and quality measurement.

Resident Assessment Instrument (RAI)

The RAI consists of three components: the MDS, Care Area Triggers (CATs), and the care plan.

According to the Centers for Medicare & Medicaid Services (CMS):

> The information in the MDS constitutes the core of the required State-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident. (CMS, 2010)

The specific features of the RAI vary minimally according to each state's regulations. Each state may add to the regulations but may not remove any requirement. Overall, however, the outcomes of this instrument are expected to provide the NAC a foundation to create an effective and workable care plan that should be based on comprehensive assessment of the resident and includes individualized interventions based on risk factors and actual problems.

Nurse Assessment Coordinator Job Description

There is currently no nationally accepted NAC job description or associated qualifications. The job responsibilities are at the discretion of the employer and could include any number of duties. Examples of this can be found in a variety of job advertisements (see Attachment). CMS requires that a registered nurse serve in a coordinating role for the RAI process, with the responsibility of signing off on completion of the document.

The position is generally referred to as "MDS coordinator," as the role requires an understanding of MDS 3.0 and RAI rules and regulations. The job requires nursing assessment skills and the ability to conceive and create care plans based on a comprehensive resident assessment that is accomplished through resident and family interviews, physical assessment, observation, and input from the care team. Nurse Practice Acts indicate variation in the role of registered nurses (RNs) and licensed practical nurses (LPNs) for nursing assessment; however, federal regulations related to the RAI clearly define what components of assessment should be addressed for persons admitted to nursing homes and the ongoing clinical decision making that is within the scope of practice of RNs but not LPNs. It is not unusual for facility administrators to hire an LPN to fulfill the responsibilities of the NAC, under the supervision of an RN.

Nurse Practice Acts and the RN and LPN Roles Related to Assessment

Nurse Practice Acts vary from state to state and are created by each state's board of nursing. Consequently, the scope of practice for an RN or licensed practical/vocational nurse (LPN/VN) varies. The National Council of State Boards of Nursing (NCSBN) created a model Nurse Practice Act to provide states with a guide when state boards of nursing modify or update the Nurse Practice Act in their particular state. NCSBN's model provides standards for nursing practice for both RNs and LPN/VNs.

NCSBN is nationally recognized as the provider of the National Council Licensure Examination for RNs (NCLEX-RN) and for LPN/VNs (NCLEX-PN). These exams are used in the United States and its territories to test applicants' nursing knowledge, skills, and abilities and to determine all licensing decisions.

RNs are required to complete either a four-year baccalaureate degree, which is also known as a bachelor's degree in nursing (BSN); a two- to three-year associate degree (AD); or a three-year diploma offered by a limited number of hospitals. These programs must be accredited. Following completion, the aspiring RN must pass the NCLEX-RN.

LPN/VN education requirements vary from state to state. Often LPN/VN programs require one year of education from an accredited or state-approved program, with some degree of clinical experience, after which the aspiring LPN/VN must pass the NCLEX-PN. Each state board of nursing has defined the licensure requirements for nurses. Though these requirements differ from state to state, there are standards of patient safety and public health to which most states adhere.

The model Nurse Practice Act for RNs written by NSCBN begins by defining a comprehensive nursing assessment and how that assessment is to be completed:

a. Providing comprehensive nursing assessment of the health status of clients.

> ***Comprehensive nursing assessment is an extensive data collection (initial and ongoing) used for individuals, families, groups and communities in addressing anticipated changes in client conditions as well as emergent changes in a client's health status; recognizing alterations to previous client conditions; synthesizing the biological, psychological, spiritual and social aspects of the client's condition; evaluating the impact of nursing care; and using this broad and complete analysis to make independent decisions and nursing diagnoses, plan nursing interventions, evaluate the need for different interventions, and assess the need to communicate and consult with other health team members. (National Council of State Boards of Nursing [NCSBN], 2010)

LPN/VNs have a more limited scope of practice in every state. LPN/VNs must work under the guidance of an RN or physician, and licensure does not support the LPN's role in developing care plans or conducting comprehensive assessments, or legally signing off on either without the signature of an RN or MD. The NCSBN provides the following guidelines regarding the provision of LPN/VN assessments in the model Nurse Practice Act:

a. Collecting data and conducting focused nursing assessments of the health status of individuals.

> ***A focused assessment is an appraisal of an individual's status and situation at hand, contributing to comprehensive assessment by the RN, supporting ongoing data collection and deciding who needs to be informed of the information and when to inform. (NCSBN, 2010)

The defined difference between RNs and LPN/VNs in the discussion of MDS coordination is best illustrated by the amount and depth of the assessment covered by the Nurse Practice Acts. The State of New York clarified this difference in 2005 with the following statement: "Of significant importance, the opinion clearly states that LPNs do not have assessment privileges and cannot interpret clinical data and/or establish or alter nursing care plans" (Zittel, 2005).

The NCSBN model creates a full, recommended Nurse Practice Act for both RNs and LPN/VNs, and then reiterates the importance of nursing assessments:

> The first step in the nursing process assessment is the basis for nursing decisions and interventions. The subcommittee believes that the first step is implemented in much the same way across jurisdictions, but that it is described and discussed very differently. The subcommittee members believe that both LPN/VNs and RNs assess, but the members identified a significant difference in the breadth, depth and comprehensiveness of the assessments conducted by the two levels of licensed nurses. These differences are reflected in the term "focused assessment" to describe the LPN/VN role in the first step of the nursing process and the term "comprehensive assessment" to describe the role of the RN. (NCSBN, 2010)

State requirements related to the RAI must follow the recommendations established by CMS. The need for the provision of a comprehensive assessment brings into focus the knowledge, skills, and

abilities needed by the NAC. The CMS regulations specifically require that an RN coordinate the comprehensive assessments necessary for completion of the RAI process. Supportive assessments completed by LPN/VNs may be used to add data to the comprehensive assessment that was completed by the RN. Many LPN/VNs provide assistance, as is allowed by RAI regulations. Understanding the significant function that LPN/VNs regularly play in the completion of the MDS 3.0 in many facilities is critical. It is imperative, however, that LPN/VNs not be asked or expected to step out of their scope of practice. Such an expectation could put them at legal risk.

Future of Nurse Assessment Coordination

The complexity of the NAC's role has clearly increased and developed since the implementation of the first MDS in 1988. Initially, NACs were often employed at a facility in an alternate role (e.g., quality assurance); the collection of data for the MDS was an added responsibility. Many of the early MDS-related responsibilities revolved around proper collection, documentation, and transmission of required data. While the MDS assessment and care planning process was recognized as a function of the RAI process, the primary focus of completing the MDS has been on regulatory adherence for purposes of reimbursement. The MDS was designed to improve resident care, and the tool has moved in that direction steadily. Initially, however, use of the MDS as a driver of resident care was a distant plan. The need for regulatory adherence continues to exist within the MDS data-collection role, but with a high level of clinical complexity and need for critical thinking. The early vision of the MDS as a tool that would lead resident care to a much higher level is now being realized. It is incumbent upon the NAC to fulfill that promise.

One study completed at the Duke University School of Nursing demonstrated how NACs (identified as MDS coordinators), when performing at a high level, improve resident care measurably. The study examined role management and communication at several long-term care facilities and found that when MDS coordinators foster new information flow and good connections among staff, the resident care improves. Additionally, the data collected were found to be more accurate, yielding higher levels of reimbursement along with a more satisfied community of residents (Piven et al., 2006). The newly released MDS 3.0 is designed to more fully augment and improve that outcome.

The Agency for Healthcare Research and Quality, of the U.S. Department of Health and Human Services, has defined care coordination this way:

> Care coordination is 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. (Shojania, McDonald, AHRQ, & University of California, 2007).

The Case Management Society of America (2010), in its Standards of Practice, defines case management guiding principles as the following:

> Case Management guiding principles, interventions, and strategies are targeted at the achievement of client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration and service facilitation. They are based on the needs and values of the client and are accomplished in collaboration with all service providers. This accomplishes care that is appropriate, effective, client-centered, timely, efficient and equitable.

The NAC's role in nursing facilities is consistent with the definitions of care coordination and case management. Judging from the newly launched MDS 3.0 and its required levels of assessment, documentation, education, care planning, team collaboration, and resident advocacy, it is evident that the NAC also needs to function as a case manager and care coordinator. The role of the NAC requires in-depth and comprehensive physical assessment skills, along with the ability to assess each resident holistically.

The American Association of Nurse Assessment Coordination (AANAC) advocates for long-term care nursing and long-term care residents. Performing a comprehensive assessment for the MDS 3.0, based on standards of nursing practice and federal and state regulations related to the RAI, clearly requires an RN, or the accountability of an RN, to adequately fulfill the NAC role. AANAC is aware that there are many instances in which LPN/VNs are fulfilling this role. An RN is required, however, to sign off on all documentation for overall accountability and to ensure adherence to federal regulations. AANAC is dedicated to supporting all nurses who are in the role of NAC and acknowledges that many LPN/VNs functioning in an NAC role do so with great success while following their professional scope of practice and heeding regulations. Observing state Nurse Practice Acts and federal RAI regulations is imperative. Ignoring these laws puts LPN/VNs at risk, which is unacceptable.

Conclusion

The American Association of Nurse Assessment Coordination has defined the NAC role so as to support the basic requirements of the position and with the aim of improving and supporting nursing care in a skilled nursing facility. The Administration on Aging (2010) estimates that by 2050, 20% of the population of the United States will be over the age of 65. Based on this projection, it is imperative that the health care community and specifically the long-term care community be prepared for this demographic change to safeguard the provision of care for the nation's elderly. The change is inevitable. The elderly who are in need of assistance will be well served by a professional community of highly informed NACs with a defined role; thus, AANAC strives to promote, define, support, and maximize the NAC role.

Federal RAI regulations clearly state that an RN must sign off on the required comprehensive assessment in the MDS 3.0 on its completion. Many communities do not have an RN available to complete the full data collection needed to meet the requirements of the MDS 3.0 and must rely on an LPN/VN to support the RN in collection of that data. AANAC encourages those communities to support their staff in achieving the educational requirements needed to move from LPN/VN to RN so that nurses are not asked to step outside their scope of practice, which puts them at legal risk. "Training may be especially valuable to MDS Coordinators because of their integral role in assessment and care planning and the challenge of balancing the clinical, regulatory, and financial aspects of their positions" (Piven et al., 2006). The optimized employment of the NAC will help avoid preventable complications and hospitalizations through improved staff communications and well-designed, person-centered care plans. Appropriate and advantageous health care delivery will lead to lower costs, more suitable reimbursement, and long-term care nursing staff and residents who are more satisfied with their work and living environments.

AANAC proposes developing a Scope and Standards of Practice for Nurse Assessment Coordinators. These standards will serve as a guide and reference for professional nurses working as NACs and for their professional development. The standards will support highly educated, focused, confident, and proactive NACs. Better care coordination and communication will translate into improved resident health, satisfaction, and outcomes, which in turn may improve census, survey outcomes, and positively impact reimbursement.

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Attachment

The following is an actual ad for a nurse assessment coordinator (Friend, 2010):

Summary:

Assists the Resident Care Management Director (RCMD) with the timely and accurate completion of both the RAI and Care Management process from admission to discharge in accordance with Company P&Ps, MPGs, State and Federal guidelines, and all other entities as appropriate (e.g., Minimum Data Set, discharge and re-entry tracking forms, etc.). With direction from the RCMD, may coordinate information systems operations and education for the clinical department.

Essential Duties and Responsibilities:

- Works in collaboration with the Interdisciplinary Team to assess the needs of the resident
- Assists with coordination and management of the daily Care Management meeting, to include review of resident care and the setting of the Assessment Reference Date
- Complies with federal and state regulations regarding completion and coordination of the RAI process
- Monitors MDS and care plan documentation for all residents. Ensures documentation is present in the medical record to support MDS coding
- Maintains current MDS status of assigned residents according to state and federal guidelines
- Supports the tracking system of MDS schedules (timeframes and due dates)
- Maintains the frequent and accurate data entry of resident information into appropriate computerized MDS programs
- Completes accurate coding of the MDS with information obtained via medical record review as well as observation and interview with facility staff, resident and family members
- At the direction of the RCMD, attends interdisciplinary team meetings and other meetings in order to gather information, communicate changes, and maintain and update records
- Continually updating knowledge base related to data entry and computer technology
- At the direction of the RCMD, may participate in quality assurance activities
- Completion of AANAC Certificate program within the first six months of employment
- Contacts Medicare Beneficiary Hotline per company policy and RCMD direction
- Completes electronic submission of required documentation to the State database and other entities per company policy.
- Performs other duties as assigned.

Requirements

Must be a Registered Nurse or Licensed Vocational Nurse.
MDS experience is REQUIRED.
Skilled Nursing experience is REQUIRED.
Experience with MDS 3.0 is a plus!

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> Care coordination is 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. (Shojania, McDonald, AHRQ, & University of California, 2007).

The Case Management Society of America (2010), in its Standards of Practice, defines case management guiding principles as the following:

> Case Management guiding principles, interventions, and strategies are targeted at the achievement of client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration and service facilitation. They are based on the needs and values of the client and are accomplished in collaboration with all service providers. This accomplishes care that is appropriate, effective, client-centered, timely, efficient and equitable.

The NAC's role in nursing facilities is consistent with the definitions of care coordination and case management. Judging from the newly launched MDS 3.0 and its required levels of assessment, documentation, education, care planning, team collaboration, and resident advocacy, it is evident that the NAC also needs to function as a case manager and care coordinator. The role of the NAC requires in-depth and comprehensive physical assessment skills, along with the ability to assess each resident holistically.

The American Association of Nurse Assessment Coordination (AANAC) advocates for long-term care nursing and long-term care residents. Performing a comprehensive assessment for the MDS 3.0, based on standards of nursing practice and federal and state regulations related to the RAI, clearly requires an RN, or the accountability of an RN, to adequately fulfill the NAC role. AANAC is aware that there are many instances in which LPN/VNs are fulfilling this role. An RN is required, however, to sign off on all documentation for overall accountability and to ensure adherence to federal regulations. AANAC is dedicated to supporting all nurses who are in the role of NAC and acknowledges that many LPN/VNs functioning in an NAC role do so with great success while following their professional scope of practice and heeding regulations. Observing state Nurse Practice Acts and federal RAI regulations is imperative. Ignoring these laws puts LPN/VNs at risk, which is unacceptable.

Conclusion

The American Association of Nurse Assessment Coordination has defined the NAC role so as to support the basic requirements of the position and with the aim of improving and supporting nursing care in a skilled nursing facility. The Administration on Aging (2010) estimates that by 2050, 20% of the population of the United States will be over the age of 65. Based on this projection, it is imperative that the health care community and specifically the long-term care community be prepared for this demographic change to safeguard the provision of care for the nation's elderly. The change is inevitable. The elderly who are in need of assistance will be well served by a professional community of highly informed NACs with a defined role; thus, AANAC strives to promote, define, support, and maximize the NAC role.

Federal RAI regulations clearly state that an RN must sign off on the required comprehensive assessment in the MDS 3.0 on its completion. Many communities do not have an RN available to complete the full data collection needed to meet the requirements of the MDS 3.0 and must rely on an LPN/VN to support the RN in collection of that data. AANAC encourages those communities to support their staff in achieving the educational requirements needed to move from LPN/VN to RN so that nurses are not asked to step outside their scope of practice, which puts them at legal risk. "Training may be especially valuable to MDS Coordinators because of their integral role in assessment and care planning and the challenge of balancing the clinical, regulatory, and financial aspects of their positions" (Piven et al., 2006). The optimized employment of the NAC will help avoid preventable complications and hospitalizations through improved staff communications and well-designed, person-centered care plans. Appropriate and advantageous health care delivery will lead to lower costs, more suitable reimbursement, and long-term care nursing staff and residents who are more satisfied with their work and living environments.

AANAC proposes developing a Scope and Standards of Practice for Nurse Assessment Coordinators. These standards will serve as a guide and reference for professional nurses working as NACs and for their professional development. The standards will support highly educated, focused, confident, and proactive NACs. Better care coordination and communication will translate into improved resident health, satisfaction, and outcomes, which in turn may improve census, survey outcomes, and positively impact reimbursement.

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Attachment

The following is an actual ad for a nurse assessment coordinator (Friend, 2010):

Summary:

Assists the Resident Care Management Director (RCMD) with the timely and accurate completion of both the RAI and Care Management process from admission to discharge in accordance with Company P&Ps, MPGs, State and Federal guidelines, and all other entities as appropriate (e.g., Minimum Data Set, discharge and re-entry tracking forms, etc.). With direction from the RCMD, may coordinate information systems operations and education for the clinical department.

Essential Duties and Responsibilities:

- Works in collaboration with the Interdisciplinary Team to assess the needs of the resident
- Assists with coordination and management of the daily Care Management meeting, to include review of resident care and the setting of the Assessment Reference Date
- Complies with federal and state regulations regarding completion and coordination of the RAI process
- Monitors MDS and care plan documentation for all residents. Ensures documentation is present in the medical record to support MDS coding
- Maintains current MDS status of assigned residents according to state and federal guidelines
- Supports the tracking system of MDS schedules (timeframes and due dates)
- Maintains the frequent and accurate data entry of resident information into appropriate computerized MDS programs
- Completes accurate coding of the MDS with information obtained via medical record review as well as observation and interview with facility staff, resident and family members
- At the direction of the RCMD, attends interdisciplinary team meetings and other meetings in order to gather information, communicate changes, and maintain and update records
- Continually updating knowledge base related to data entry and computer technology
- At the direction of the RCMD, may participate in quality assurance activities
- Completion of AANAC Certificate program within the first six months of employment
- Contacts Medicare Beneficiary Hotline per company policy and RCMD direction
- Completes electronic submission of required documentation to the State database and other entities per company policy.
- Performs other duties as assigned.

Requirements

Must be a Registered Nurse or Licensed Vocational Nurse.
MDS experience is REQUIRED.
Skilled Nursing experience is REQUIRED.
Experience with MDS 3.0 is a plus!