

A Multi-Domain Taxonomy of Advanced Nurse Led Care Coordination for Complex and Chronic Care

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ABSTRACT: Health systems increasingly face fragmentation as chronic disease and multimorbidity require care spanning multiple providers, settings, and sectors. Advanced practice nurses are often positioned as care coordinators, yet nurse-led coordination remains variably defined and operationalized. This study aimed to develop a comprehensive, practice-oriented taxonomy of advanced nurse-led care coordination strategies for complex and chronic care. A conceptual framework development design integrated concept clarification, theory-informed synthesis, and classification-oriented evidence mapping, drawing on literature on care coordination, transitional care, chronic disease management, and nurse navigator/coordinator roles to identify recurring coordination activities. The analysis produced a multi-domain taxonomy spanning assessment, planning, transition, monitoring, and evaluation. Core activities attributable to advanced nurse roles included patient identification and multidimensional assessment, information brokerage, navigation and cross-sector linkage, longitudinal monitoring, and patient/caregiver coaching. The taxonomy integrates transitional care mechanisms with longitudinal chronic care processes, addressing under-specified areas such as role accountability, communication systems, and evaluative feedback loops. Nurse-led coordination was most consistently linked to improved patient experience, perceived support, and continuity, while utilization effects varied by context. The proposed taxonomy advances conceptual clarity and operational specificity, offering a scaffold for program design, workforce development, policy decision-making, and further empirical testing.

Keywords: Care Coordination, Advanced Practice Nursing, Chronic Disease, Multimorbidity, Transitional Care, Integrated Care.



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INTRODUCTION

Across contemporary health systems, the burden of chronic disease and multimorbidity is consistently described as increasing in both prevalence and complexity, generating sustained

demand for longitudinal care that traverses multiple settings, providers, and service systems. Demographic ageing and epidemiological transition have intensified the number of individuals living with multiple long-term conditions, often accompanied by functional decline, psychosocial vulnerability, and ongoing support needs. The literature repeatedly argues that historically dominant models of care delivery characterised by episodic encounters, specialty-based silos, and institution-centred organisation are poorly aligned with these trajectories of need, which require continuous, coordinated, and person-centred responses rather than discrete, time-limited interventions (Davis et al., 2019; Khair & Chaplin, 2017; Veras & Cordeiro, 2019). As a result, chronic illness and multimorbidity have become not only clinical challenges but also structural stressors that expose limitations in how health systems organise, connect, and govern care across boundaries.

A central consequence of this misalignment is care fragmentation. Across diverse contexts, fragmentation is described as the disruption of care pathways through discontinuities, unclear allocation of responsibility, and poorly connected services operating across organisational, professional, and sectoral divides. Individuals with complex chronic conditions commonly navigate parallel systems such as primary care, specialist services, hospitals, community health, and social support, each governed by distinct funding arrangements, documentation systems, and accountability structures (Nabelsi & Plouffe, 2024). Studies focused on older adults and people with multimorbidity explicitly link the rising burden of chronic disease to increased fragmentation risk, arguing that complexity arises not only from the number of conditions but from the volume of interdependencies that must be managed across care interfaces (Sobis, 2023). Empirical work from Quebec highlights how fragmentation interrupts “interfacility service corridors,” producing adverse effects when sustained collaboration across settings cannot be reliably achieved (Nabelsi & Plouffe, 2024). Similar patterns are reported in mental health, oncology, palliative care, and veteran health systems, where pathways span multiple organisations and blurred service boundaries intensify coordination challenges (Hannigan et al., 2018; Maguire et al., 2022; Reeves et al., 2020).

Within this context, care coordination has emerged as a central organising concept in health services and nursing scholarship. Broadly, contemporary literature converges on coordination as purposive work aimed at ensuring that individuals’ needs are identified and met through appropriately connected services across time and settings. However, despite this general agreement, persistent definitional inconsistency and boundary ambiguity are widely acknowledged (Anderson & Hewner, 2021; Colombani et al., 2019). Coordination is frequently discussed alongside, or interchangeably with, constructs such as continuity of care, integration, and case management, complicating theoretical clarity and empirical measurement (Weaver et al., 2017). In cross-national mental health systems research, coordination is framed as an explicit policy function designed to align services to meet needs, often formalised through designated coordination roles (Hannigan et al., 2018). Yet systematic appraisals of continuity and coordination concepts continue to note incomplete consensus regarding core attributes, mechanisms, and boundaries, particularly where coordination spans multiple service systems and professional jurisdictions.

Nursing scholarship has both contributed to and highlighted these conceptual challenges. Formal concept analyses identify care coordination as a widely used but variably defined construct within

nursing, documenting limited role clarity both across disciplines and within nursing itself (Anderson & Hewner, 2021). At the same time, person-centred coordinated care literature has sought to refine coordination definitions by grounding them in service-user narratives, emphasising that coordination is not solely logistical linkage but alignment of services with what matters to individuals across their care journeys (Phelan et al., 2021; Schor, 2019). Paediatric and school health literature further extends coordination beyond intramural healthcare communication, explicitly incorporating shared responsibilities with education, social, and community systems on which children and families depend (Baker et al., 2016; Schor, 2019). These perspectives underscore that coordination must be understood as relational, communicative, and cross-system work rather than a narrow administrative function.

Against this conceptual backdrop, advanced practice nurses and expanded nursing roles are repeatedly positioned as structural responses to fragmentation in chronic and complex care. Across primary care, specialty services, community health, and integrated care initiatives, nurse-led and nurse-coordinator roles are introduced to stabilise pathways, sustain follow-up, and translate care across settings (McMurray et al., 2018). However, the literature also notes that these roles are often implemented more rapidly than they are consistently defined or standardised, generating heterogeneity in scope, accountability, and evaluation (Clarke et al., 2024). Efforts to define “nurse-led models of care” explicitly highlight inconsistent usage of the term, raising concerns about implementation fidelity and comparative assessment across contexts (Clarke et al., 2024).

Empirical studies nevertheless reveal recurring coordination functions performed by advanced practice nurses. These include navigation and pathway management across multiple providers, condition- and population-specific coordination for complex needs, cross-system linkage between health and social services, and culturally responsive facilitation of access and care planning (Chua et al., 2022; Monas et al., 2017). In oncology and palliative care, nurse coordinators are characterised by their availability to patients, symptom management expertise, and integrative roles within multidisciplinary teams, although variability in role perception persists (Colombani et al., 2019; Reeves et al., 2020). In veteran and rural health contexts, nurse-led coordination explicitly bridges institutional systems with distinct governance and eligibility rules, highlighting coordination as boundary-spanning work rather than intra-organisational support (Howren et al., 2021). Importantly, advanced practice nursing roles frequently integrate clinical decision-making with coordination and navigation, reflecting the inseparability of clinical expertise and coordination in complex chronic care.

The emphasis on coordination is reinforced by evidence linking fragmentation and inadequate coordination with adverse outcomes. Across multiple settings, poor coordination is associated with interrupted pathways, unmet needs, and avoidable service use, particularly among people with chronic and complex conditions (Sobis, 2023; Nabelsi & Plouffe, 2024). Coordinated care is repeatedly framed as a strategy to reduce hospital readmissions and emergency department utilisation, and quantitative program evaluations explicitly position coordination as a mechanism to address avoidable acute care use (Mallitt et al., 2016). Transitional care research further demonstrates that periods of transfer between settings represent heightened vulnerability, where failures in communication and follow-up expose patients to risk, even when evidence-based models exist but are inconsistently implemented (Allen et al., 2020; Magagnin et al., 2022). From

a patient-experience perspective, coordination deficits are salient to service users, particularly during discharge and transitions, where unmet informational and support needs are prominent (Jesus et al., 2024).

At the same time, the literature cautions against over-specific claims where evidence is indirect. For example, while medication safety is widely recognised as dependent on effective coordination and information continuity, the present body of evidence more strongly supports coordination as a vulnerability point during transitions rather than as a consistently quantified predictor of medication error incidence (Baker et al., 2022). Nursing research also highlights structural tensions between confidentiality, privacy governance, and coordination, particularly in digital and cross-system contexts, suggesting that information-sharing constraints may undermine coordination even when roles and intentions are clear (Ibrahim et al., 2024).

Transitional care and chronic care models further illustrate how nursing leadership is embedded within coordination-oriented reforms. Across stroke care, older-person care, and youth transitions, nursing roles are central to communication, handover, and continuity across settings, even as implementation gaps persist (McCallum, 2017). Chronic care redesign initiatives explicitly position nurses as coordinators and navigators for people with multimorbidity, framing coordination as a sustained, person-centred function rather than episodic case management (Lowe, 2017). Integrated care evaluations of nurse navigator roles in primary health care similarly emphasise nursing leadership as a mechanism to bridge longstanding gaps, particularly in rural and underserved contexts (Robinson et al., 2024).

Despite this substantial body of work, important conceptual gaps remain. The literature consistently identifies persistent definitional inconsistency, unclear role boundaries, and insufficient specification of accountability and interprofessional interfaces in nurse-led coordination (Anderson & Hewner, 2021; Colombani et al., 2019). Communication systems are widely recognised as essential to coordination yet are often under-operationalised in frameworks, leaving abstract principles disconnected from real-world tools, documentation practices, and governance arrangements (Baker et al., 2022; Allen et al., 2020). Moreover, person-centredness and lived experience are not consistently integrated into coordination theory, despite evidence that patient-defined priorities and contextual constraints shape how coordination is experienced and enacted (Alamrani & Birnbaum, 2024). Cross-system coordination and privacy-governance tensions are similarly under-theorised, even though many coordination roles operate at the intersection of distinct institutional systems with divergent rules and expectations (Maguire et al., 2022; Ibrahim et al., 2024).

Taken together, this literature indicates that the challenge in nurse-led care coordination lies less in the absence of coordination principles and more in the lack of structured, operational frameworks that integrate definitions, roles, processes, tools, and outcomes in a coherent and transferable manner. In response, the present study aims to develop a comprehensive taxonomy of advanced nurse led care coordination strategies that systematically organises coordination work across domains, clarifies interprofessional interfaces, and aligns coordination processes with patient-, professional-, and system-level outcomes. By addressing these conceptual gaps, the study

seeks to strengthen the theoretical foundation and practical applicability of advanced nurse led care coordination in complex and chronic care contexts.

METHOD

Study Design and Methodological Orientation

This study employed a conceptual framework development design aimed at producing a practice-oriented taxonomy of advanced nurse led care coordination strategies for complex and chronic care. Conceptual development was selected because the target phenomenon care coordination led by advanced nurses has been repeatedly described as widely invoked yet variably defined, with persistent boundary ambiguity relative to continuity, integration, and case management, and recurring role ambiguity across and within disciplines (Anderson & Hewner, 2021; Weaver et al., 2017; Colombani et al., 2019). In such contexts, conceptual research is appropriate to consolidate dispersed evidence, clarify constructs, and generate an operational structure that can guide implementation and evaluation.

The methodological orientation draws on established approaches commonly used in nursing and health services research for conceptual model and taxonomy development, including concept clarification techniques, theory synthesis/model building, and evidence synthesis approaches oriented toward classification rather than effect estimation alone (Ghorbani et al., 2022; Raftery et al., 2016). Recognising that coordination work is inherently context dependent, this design also incorporated principles from stakeholder-engaged and practice-informed framework development, where conceptual outputs are treated as implementable artefacts that must align with operational realities and system constraints (Phelan et al., 2021).

Conceptual Development Approach

The taxonomy was constructed through a staged synthesis process intended to make derivation traceable from inputs to outputs. The staging logic aligns with recommendations that conceptual development should use explicit, reproducible procedures to mitigate the risks posed by definitional inconsistency and role ambiguity (Anderson & Hewner, 2021; Baker et al., 2022). The approach integrated (i) concept clarification to stabilise the meaning and boundaries of care coordination, (ii) structured evidence mapping to identify candidate domains and their defining characteristics, and (iii) iterative refinement to translate abstract domains into operational definitions, implementation steps, tools, partners, and targeted outcomes.

First, the study adopted a concept clarification stance that reflects the function of formal concept analysis in nursing scholarship: moving from diffuse and inconsistent usage toward operational definitions and candidate attributes suitable for later measurement and intervention development (Anderson & Hewner, 2021; Baker et al., 2022). While the present study did not aim to replicate a full concept analysis protocol in isolation, it applied the same logic by explicitly extracting defining elements that recur in coordination scholarship particularly the emphasis on purposive processes,

systems of communication, role/accountability structures, and cross-system linkage and then using these as analytic lenses for domain identification (Schor, 2019).

Second, the study used theory-informed model building principles consistent with theory synthesis approaches in nursing, where existing propositions and empirical findings are combined into a coherent structure through staged synthesis procedures (Bekhet, 2022). This stage prioritised internal coherence between the taxonomy's conceptual domains and their operational expressions. Congruence between theoretical and operational definitions was treated as essential to ensure that domains could be translated into program components and measurable indicators, addressing the critique that models may be implemented faster than their conceptual foundations stabilise (Bekhet, 2022; Colombani et al., 2019).

Third, recognising that care coordination is a complex, heterogeneous field spanning multiple settings and populations, the study adopted an evidence synthesis approach oriented toward taxonomy building. This aligns with health services research where systematic appraisals, integrative reviews, and mapping studies are used to consolidate overlapping constructs and produce multidimensional models and typologies (Duan-Porter et al., 2021). Such approaches are particularly relevant where coordination intersects with transitional care, chronic care redesign, and navigation programs, each with diverse components and contextual determinants (Chakurian & Popejoy, 2021).

Evidence Identification and Data Sources

Evidence inputs were identified from contemporary nursing and health services literature addressing care coordination, continuity, transitional care, chronic disease management, nurse navigator and nurse coordinator roles, and cross-sector integration. The evidence base intentionally included multiple study types, reflecting the recommendation that framework development for heterogeneous domains often requires integrative and scoping-style mapping rather than reliance on a single design tradition (Anthonisen et al., 2022).

Three complementary evidence streams were prioritised. The first stream consisted of concept analyses and conceptual papers that clarify care coordination definitions and attributes, including emphasis on communication systems and operational context (Anderson & Hewner, 2021; Baker et al., 2022). The second stream comprised systematic reviews and appraisals that synthesise continuity and coordination constructs into multidimensional models and examine measurement considerations, thereby supporting domain mapping and boundary clarification (Weaver et al., 2017; Duan-Porter et al., 2021). The third stream included empirical program and mixed-method studies describing nurse-led or nurse-coordinator roles across settings (e.g., oncology, palliative care, integrated primary care, veteran care), used to extract concrete coordination activities, interfaces, and tools relevant to implementable taxonomy (Maguire et al., 2022).

Because coordination is shaped by governance and information-sharing constraints, the evidence base also included sources addressing cross-system collaboration and information governance tensions, consistent with calls to incorporate structural constraints into coordination frameworks

(Hannigan et al., 2018). This ensured that the taxonomy would not treat coordination as an abstract ideal detached from real-world constraints.

Data Extraction and Analytic Procedure

Data extraction focused on identifying and describing care coordination activities that are led, orchestrated, or substantially contributed to by advanced practice nurses or expanded nursing roles. Extraction was undertaken at the level of “strategy elements,” defined as discrete but meaningful units of coordination work (e.g., risk stratification for caseload triage, medication reconciliation, structured handover, case conferencing, cross-sector referral tracking). This element-level approach is consistent with prior synthesis strategies for heterogeneous nurse-led interventions, where interventions are decomposed into constituent components (“active ingredients”) and then related to outcomes and implementation contexts (Conway et al., 2017).

The analysis proceeded through five iterative steps.

1. Element compilation. Coordination elements were compiled from the evidence base and practice-oriented descriptions, retaining original terminology where possible to preserve interpretive fidelity.
2. Initial categorisation into domains. Elements were grouped by functional similarity across the continuum of care (assessment, planning, transition, monitoring, evaluation), reflecting common organising logics in coordination frameworks and transitional care synthesis.
3. Domain definition and boundary testing. Each candidate domain was assigned a preliminary operational definition. Boundaries between domains were tested against recurring definitional problems in the literature particularly overlaps between coordination, continuity, and integration and refined to reduce ambiguity.
4. Operational mapping. For each domain, the study mapped (i) core implementation steps, (ii) key interprofessional partners and interfaces, (iii) commonly used artefacts and tools (e.g., shared care plans, dashboards, SBAR templates), and (iv) targeted outcomes. This operational mapping responds to critiques that coordination concepts often under-specify communication infrastructures and role-accountability structures required for real-world enactment.
5. Iterative refinement for implementability. Domains and operational components were refined to ensure internal coherence and implementability across contexts. The refinement logic reflects recommendations from stakeholder-engaged and action research approaches that treat frameworks as iterative products aligned with lived experience and operational feasibility.

Ensuring Rigor, Transparency, and Reproducibility

Several design features were incorporated to support rigor and transparency, consistent with methodological criteria recommended for conceptual or framework-development studies.

First, the study used explicit staging and documented analytic steps to provide traceability from evidence inputs to taxonomy outputs, aligning with calls for reproducible derivation procedures in concept and theory synthesis work (Ghorbani et al., 2022).

Second, evidence identification emphasised transparent inclusion of multiple study types and explicit attention to measurement and quality appraisal traditions within coordination scholarship. Conceptual and measurement appraisals of continuity and coordination highlight the importance of considering evidence quality and measurement validity when constructing domain frameworks (Weaver et al., 2017). In intervention-focused syntheses, the use of established appraisal approaches (e.g., risk of bias and GRADE) illustrates that conclusions about which components matter should be conditioned on evidence strength and uncertainty (Conway et al., 2017; Jesus et al., 2024). In the present study, uncertainty was addressed by distinguishing between elements that are strongly grounded in recurring evidence patterns (e.g., communication and transitional care processes) and those that may be contextually variable or less consistently evidenced across settings.

Third, the taxonomy was developed with explicit context specification. Comparative qualitative research demonstrates that coordination is shaped by structural features such as funding arrangements, organisational management, and electronic record systems; omitting these contextual determinants risks producing decontextualised models that are difficult to implement or evaluate (Sobis, 2023). Accordingly, the taxonomy explicitly includes interprofessional partners, tools, and cross-sector linkages as part of each domain's operational structure.

Fourth, the taxonomy design incorporated governance and information-sharing constraints as conceptual modifiers, rather than external limitations. Evidence on confidentiality versus coordination in digital contexts indicates that privacy frameworks and data-sharing agreements materially shape the feasibility of coordination processes (Ibrahim et al., 2024). The taxonomy therefore conceptualises communication not only as interaction but as structured, governed information transfer.

Finally, the framework was constructed to support future implementation fidelity assessment. Methodological guidance in complex and pragmatic interventions indicates that attributing outcomes to coordination components requires explicit procedures for monitoring whether components are delivered as intended (Ginsburg et al., 2021; Palmer et al., 2019). By specifying core implementation steps and tools for each domain, the taxonomy provides a basis for later fidelity indicators and process evaluation.

Outputs and Intended Uses of the Taxonomy

The primary output of the study is a multi-domain taxonomy that defines advanced nurse led care coordination strategies through operational definitions, implementation steps, partner roles, tools/artefacts, and targeted outcomes. The taxonomy is intended to support three uses: (i) program design and workforce role specification, addressing recurrent concerns about role ambiguity and inconsistent definition of nurse-led models (Khair & Chaplin, 2017); (ii) evaluation planning, by linking domains to outcome classes and enabling future measurement selection and

fidelity assessment; and (iii) comparative research, by providing a common analytic schema to synthesise heterogeneous nurse-led coordination interventions across contexts and settings.

In summary, the methodological approach integrates concept clarification, theory-informed synthesis, and classification-oriented evidence mapping, strengthened by explicit staging, context specification, and attention to governance constraints. This design is intended to generate a taxonomy that is not only conceptually coherent but operationally usable, thereby enabling subsequent empirical validation and implementation research.

RESULT AND DISCUSSION

Table 1. Taxonomy of Advanced Nurse Led Care Coordination Strategies in Complex and Chronic Care

Domain	Operational Definition	Core Coordination Activities	Key Interprofessional / Cross-Sector Partners	Tools & Artefacts	Targeted Outcomes
Assessment	Systematic identification and multidimensional appraisal of patients' clinical, psychosocial, functional, and contextual needs to inform coordinated care pathways.	Case finding and eligibility screening; risk stratification; comprehensive biopsychosocial assessment; review of care history across settings; assessment of system constraints (e.g., eligibility, access).	Primary care physicians; specialists; community nurses; social workers; patients and carers.	Assessment instruments; referral criteria; shared electronic health records; intake templates.	Accurate targeting of high-need patients; early identification of coordination risks; improved pathway alignment.
Person-Centred Care Planning	Co-design of an individualized, shared care plan that aligns goals, preferences, and responsibilities across providers and settings.	Goal setting with patients/carers; shared decision-making; delineation of roles and responsibilities; development of shared care plans; alignment of services across sectors.	Patients and carers; GPs; allied health professionals; community services; social care agencies.	Individualized care plans; goal-setting tools; consent documentation; shared planning platforms.	Improved goal concordance; clarity of responsibility; enhanced patient engagement and continuity.
Care Transition Management	Coordination of information, responsibility, and support during transfers	Structured handover; discharge preparation; medication reconciliation; referral tracking;	Hospital teams; primary care; pharmacists; community health services; family carers.	Discharge summaries; handover tools (e.g., SBAR); digital referral	Reduced transition-related errors; improved continuity; lower

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	between settings to reduce transition-related risk.	post-discharge follow-up linkage.		platforms; transition checklists.	readmission risk.
Medication Management & Polypharmacy Coordination	Oversight and coordination of medication-related processes across providers and transitions to support safe and appropriate use.	Medication reconciliation; coordination with prescribers; patient education; monitoring adherence and adverse effects; escalation of concerns.	Physicians; pharmacists; patients and carers; community nursing services.	Medication lists; reconciliation tools; electronic prescribing systems; patient education materials.	Reduced medication discrepancies; improved medication understanding; safer transitions.
Navigation & Cross-Sector Linkage	Active guidance and advocacy to connect patients with appropriate health, social, and community services across systems.	Service mapping; referral coordination; eligibility/enrolment support; advocacy; follow-up with external services.	Community organizations; social care agencies; veterans' services; education or housing services; patients/carers.	Referral directories; navigation logs; eligibility forms; interagency communication tools.	Improved access to services; reduced unmet needs; enhanced system navigability.
Longitudinal Monitoring & Follow-Up	Sustained oversight of patient status and care plan implementation over time to maintain continuity and respond to change.	Regular follow-up contacts; symptom monitoring; surveillance of care plan adherence; escalation and troubleshooting; coordination of reviews.	Primary care teams; specialists; community nurses; allied health professionals.	Monitoring protocols; follow-up schedules; dashboards; telehealth platforms.	Improved continuity; early detection of deterioration; reduced avoidable escalation.
Patient & Caregiver Coaching and Support	Provision of informational, emotional, and self-management support to patients and carers as part of coordination work.	Education and coaching; emotional support; guidance through care pathways; reinforcement of self-management strategies.	Patients; carers; multidisciplinary care teams; community support services.	Educational resources; coaching tools; self-management plans; communication aids.	Improved patient understanding; reduced caregiver burden; enhanced self-efficacy.

Domain	Operational Definition	Core Coordination Activities	Key Interprofessional / Cross-Sector Partners	Tools & Artefacts	Targeted Outcomes
Interprofessional Communication & Case Conferencing	Facilitation of structured, ongoing communication among professionals to align care and resolve coordination challenges.	Case conferencing; multidisciplinary meetings; information synthesis; clarification of roles; conflict resolution.	Physicians; nurses; allied health professionals; social care providers.	Case conference templates; shared records; communication protocols.	Improved team alignment; reduced duplication; clearer accountability.
Digital Coordination & Information Governance	Use of digital systems to support secure information sharing and visibility while complying with privacy and governance requirements.	Management of digital workflows; secure information transmission; tracking referrals and tasks; ensuring consent and access controls.	IT services; clinical teams; privacy/governance bodies; patients/carers.	Electronic health records; coordination platforms; access control systems; audit trails.	Enhanced information continuity; safer data sharing; scalable coordination processes.
Evaluation & Data-Driven Quality Improvement	Systematic review of outcomes and processes to refine coordination practices and ensure fidelity.	Outcome tracking; patient experience measurement; fidelity assessment; feedback loops; iterative model refinement.	Service managers; quality improvement teams; clinicians; patients/carers.	Outcome indicators; patient-reported measures; audit tools; QI dashboards.	Improved service performance; learning and adaptation; evidence-informed coordination.

Note: The domains are interrelated and operate synergistically across the care continuum rather than as linear or isolated activities.

Overview of Taxonomy Development Output

The primary output of this study is a practice-oriented taxonomy that organises advanced practice nurse led care coordination into interrelated domains spanning the continuum of care. The taxonomy responds to two recurring empirical realities documented in the literature: first, advanced nursing coordination roles are widely implemented across chronic and complex care settings but vary substantially in title, scope, and local enactment; second, this variability complicates replication, evaluation, and cross-context learning (Monas et al., 2017). To address this, the taxonomy specifies (i) core coordination activities attributable to advanced nursing roles, (ii) a continuum-based categorisation of strategies across assessment, planning, transition, monitoring, and evaluation, and (iii) explicit operational components including implementation steps, key partnerships, tools/artefacts, and targeted outcomes.

Coordination Activities Most Frequently Attributed to Advanced Practice Nurses

Across chronic and complex care contexts, the evidence consistently attributes a recurring cluster of coordination activities to advanced practice nurses, nurse navigators, and nurse coordinators. These activities form the empirical backbone of the taxonomy.

Patient identification and multidimensional needs assessment

A foundational activity is systematic patient identification (case finding) and needs assessment, where nurse-led programs begin by identifying eligible or high-need patients and assessing clinical, psychosocial, and contextual needs to tailor follow-up and service linkage (Magagnin et al., 2022). This assessment work is frequently described as inseparable from understanding a patient's care history and trajectory across settings (primary, secondary, community), because fragmentation risk increases when interdependencies across services are not visible or managed (Nabelsi & Plouffe, 2024).

Information brokerage and communication facilitation

A second recurring activity is information brokerage: securing, transmitting, translating, and tracking information among professionals, settings, and often patients and families as a prerequisite for continuity (McMurray et al., 2018; Allen et al., 2020). Evidence from digital pathway interventions illustrates this concretely through mechanisms such as secure information transmission and tracking of referrals and pending follow-up tasks across facilities (Nabelsi & Plouffe, 2024). Conceptual nursing work further supports communication as central, identifying “systems of communication” as an essential attribute of nurse-led care coordination requiring individualized plans, consented information sharing, and clear role delineation (Baker et al., 2022, 2016).

Navigation and linkage to services, including cross-sector and cross-system bridging

Navigation and service linkage is repeatedly described as a core coordination function, including advocacy and bridging across institutional and sectoral boundaries (Maguire et al., 2022; Schor, 2019). In rural veteran contexts, nurse-led coordination includes screening, preference-sensitive linkage, and practical support with eligibility and enrollment to connect individuals to appropriate services across systems (Howren et al., 2021), consistent with qualitative accounts of system navigability problems among veteran families (Maguire et al., 2022). In culturally and linguistically diverse populations, nurse-led coordination is described as addressing unmet coordination needs through advocacy, chart review, follow-up with external services, and explicit cross-sector coordination (Chua et al., 2022). These findings align with broader claims that coordination increasingly entails shared responsibilities beyond healthcare alone, incorporating social and community systems that shape patient outcomes (Schor, 2019; Baker et al., 2016).

Longitudinal follow-up, monitoring, and troubleshooting

Longitudinal follow-up and monitoring is a fourth recurrent activity. Systematic review evidence indicates that nurse care coordination is more likely to yield favorable patient and service outcomes when it includes frequent contact and sustained follow-up/monitoring, including transition care and behavior-change principles (Conway et al., 2017). Condition-specific advanced practice nursing programs similarly embed monitoring within coordination; for example, chronic wound management models integrate clinical oversight with care pathway coordination to improve continuity and reduce avoidable specialist referrals. Transitional care perspectives also highlight ongoing follow-up and troubleshooting as critical to preventing post-discharge fragmentation and escalation (Allen et al., 2020; Magagnin et al., 2022).

Patient/caregiver guidance, emotional support, and coaching

Finally, patient-facing guidance is frequently integrated into coordination. Oncology nurse coordinators are described as more available and as providing symptom-control expertise, emotional support, and treatment guidance while coordinating care with multiple providers. Patient narratives from navigation programs similarly emphasize informational and emotional reassurance as salient coordination benefits (Teng et al., 2021). This supports person-centred descriptions of coordination as experienced across a fragmented journey over time rather than as a purely administrative linkage function (Phelan et al., 2021).

Continuum-Based Categorisation of Coordination Strategies

Synthesizing the literature, coordination strategies can be categorised along a continuum of care assessment, planning, transition, monitoring, and evaluation reflecting how coordination is enacted across time and settings while also making visible recurrent implementation gaps (Reeves et al., 2020).

Assessment: identification, risk stratification, and context appraisal

Assessment includes case finding, risk stratification, and multidimensional needs assessment across clinical, functional, and social domains relevant to downstream pathway planning (Veras & Cordeiro, 2019). Transitional care evidence shows that assessment must include not only patient needs but also organizational and information constraints that shape feasible follow-up, highlighting assessment as both clinical and system appraisal. In cross-system contexts, assessment may include eligibility and preferences, making it simultaneously clinical and administrative triage (Maguire et al., 2022).

Planning: care plan co-design, goal alignment, and role allocation

Planning consists of constructing or refining individualized, person-centred plans that can be shared across a team, with explicit delineation of roles and responsibilities (Lowe, 2017; Phelan et al., 2021). Person-centred coordinated care emphasises that planning should incorporate service-user expectations and scaffold services across settings over time. Policy reforms similarly place the shared care plan at the centre of team-based coordination, enabling collaboration across medical, nursing, allied health, and out-of-hospital services (Lowe, 2017).

Transition: handover, discharge preparation, and interfacility transfer

Transitions are repeatedly presented as high-risk coordination points requiring intensified processes, particularly in older adult care and post-stroke pathways (Allen et al., 2020). Practitioner perspectives describe transitional coordination through team discussion, discharge questioning, and active patient/carer engagement, collectively functioning as a transition domain to reduce discontinuities between acute and community services (Allen et al., 2020). Digital transfer pathways likewise demonstrate transition coordination as structured information transmission and referral tracking across facilities (Nabelsi & Plouffe, 2024). Integrative synthesis also suggests that communication dominates transitional care models while accountability may be under-addressed, implying that transition strategies should explicitly incorporate role ownership and escalation pathways (Chakurian & Popejoy, 2021; Anderson & Hewner, 2021).

Monitoring: longitudinal follow-up, surveillance, and escalation

Monitoring encompasses structured follow-up contacts and ongoing oversight to maintain continuity and respond to change. Evidence indicates that sufficient intensity and continuity over time are important for favorable outcome patterns, though impacts vary. Monitoring may be enacted through direct patient follow-up and distributed capability building; for example, advanced practice nursing programs can upskill clinical teams to sustain continuity in routine settings (Jiménez-García et al., 2019). Cross-national research also implies that dedicated personnel per patient improves information flow and relational continuity an organizational expression of monitoring (McMurray et al., 2018).

Evaluation: outcome tracking, experience feedback, fidelity, and iterative refinement

Evaluation includes review of progress and plan adaptation, measurement of outcomes and experience, and iterative refinement of the model or. Action research models embed iterative cycles as intrinsic elements of coordination rather than post hoc assessment (Davis et al., 2019). Patient-experience systematic review evidence supports measuring patient-reported experience outcomes even when effects are mixed or neutral and bias risks are substantial, underscoring the need for rigorous evaluation design (Jesus et al., 2024). Complex intervention guidance further emphasizes fidelity assessment to interpret outcomes and distinguish core elements from adaptable components (Palmer et al., 2019; Ginsburg et al., 2021).

Essential Interprofessional Partnerships in Nurse-Led Coordination

The evidence depicts nurse-led coordination as inherently interprofessional and often intersectoral because fragmentation arises across levels of care and across governance and information systems (Maguire et al., 2022). Core partnerships recur across the literature.

First, coordination routinely requires close collaboration with physicians in both primary and specialty care to align treatment decisions, escalation plans, and follow-up scheduling (Lowe, 2017; Reeves et al., 2020). Second, allied health professionals (rehabilitation, mental health practitioners, pharmacists) are essential for functional support, symptom management, and medication-related risk mitigation, especially in multimorbidity (Magagnin et al., 2022; Conway et al., 2017). Third, community and primary care services are central partners in continuity, particularly when nurse-led coordination aims to shift utilization from acute care to planned community-based support (Mallitt et al., 2016; Nystrom et al., 2024). Fourth, social care agencies and community organisations are critical when coordination must address non-medical determinants and cross-sector needs; palliative care integration studies underscore that fragmentation across health and social care is a persistent barrier requiring multi-dimensional partnership alignment (Reeves et al., 2020). Finally, patients, families, and carers function as active coordination participants; evidence in palliative home care shows that unclear coordinator roles and weak communication can shift coordination burdens onto relatives, making role clarity and partnership design essential to avoid unintended caregiver overburden (Reeves et al., 2020).

Tools, Artefacts, and Digital Systems Used to Operationalize Coordination

Operationalization of nurse-led coordination is mediated by tools and artefacts that enable information continuity, shared visibility, and role accountability (Sobis, 2023).

Digital platforms and shared information systems

Digital platforms are described as enabling interfacility coordination through secure information transmission, visibility of pending tasks, and referral tracking (Nabelsi & Plouffe, 2024). Broader care model proposals emphasize the importance of high-quality information systems and accessible records that capture clinical and social characteristics to support coordinated care (Veras & Cordeiro, 2019). However, digital coordination is constrained by governance and confidentiality requirements; empirical nursing evidence highlights tensions between maintaining confidentiality and enabling coordination, implying that privacy frameworks and access controls are integral design conditions of operational coordination systems (Ibrahim et al., 2024).

Shared care plans and individualized planning artefacts

Individualized care plans are frequently identified as operational artefacts that encode goals, responsibilities, and communication routines. School nurse analyses specify that communication systems are enacted through individualized plans shared via information systems with consented

information sharing and explicit role delineation (Baker et al., 2022). Health system reforms similarly center co-designed care plans coordinated across multidisciplinary teams (Lowe, 2017), aligning with person-centred coordinated care descriptors that emphasize scaffolding services across time and settings (Phelan et al., 2021).

Measurement, evaluation, and fidelity tools

Evaluation instruments render coordination observable and improvable. Patient-experience systematic review evidence supports using standardized patient experience measures in evaluating coordination, discharge support, and transitional care interventions, while cautioning that effects are mixed and bias risks can be substantial (Jesus et al., 2024). Complex intervention research further emphasizes the importance of fidelity assessment procedures to interpret outcomes and understand whether core coordination elements were delivered as intended (Ginsburg et al., 2021). Conceptual and empirical mental health research also suggests a need for tools that capture enacted coordination work, given the divergence between coordination “as imagined” in policy and “as done” in practice under administrative pressures (Anderson & Hewner, 2021).

Domain Outcome Linkages Across Patient, Process, and System Outcomes

The evidence supports domain outcome linkages most strongly through associative and mechanism-informed pathways rather than uniform causal attribution across all settings, with multiple reviews noting variability and context dependence (Weaver et al., 2017).

Patient-level outcomes

Patient-level outcomes most sensitive to nurse-led coordination improvements cluster around patient experience, perceived support, understanding, and burden. Qualitative evidence from navigation programs emphasizes informational and emotional reassurance as salient benefits, and primary care nurse navigator evaluations highlight satisfaction linked to communication and coordination improvements (McMurray et al., 2018). For culturally and linguistically diverse populations, nurse-led coordination is reported to improve access to external services and patient understanding of conditions and treatments, directly addressing unmet needs arising from fragmented pathways and communication barriers (Phelan et al., 2021). However, systematic review evidence indicates that effects on standardized patient experience measures are often mixed or neutral, highlighting sensitivity to intervention design and evaluation quality (Jesus et al., 2024). Caregiver burden also emerges as responsive to role clarity and communication, with palliative home care research documenting how unclear coordination can shift burdens onto relatives (Reeves et al., 2020).

Professional and process outcomes

Coordination strategies are repeatedly linked to professional and process outcomes through improved communication, clearer pathways, and reduced discontinuities especially during transitions though impacts depend on organisational alignment and accountability (Nabelsi & Plouffe, 2024). Digital interfacility transfer tools illustrate process improvements via secured information transmission and increased continuity perceptions (Nabelsi & Plouffe, 2024). Transitional care perspectives describe team discussion, discharge questioning, and patient/carer engagement as process mechanisms intended to improve integrated transitions (Allen et al., 2020; Magagnin et al., 2022). Role clarity is a critical process determinant: palliative research identifies ambiguity in the key coordinator role and weak communication as conditions leading to conflicting understandings and inappropriate task shifting to families, implying that explicit accountability and communication routines are essential to reduce duplication and gaps (Reeves et al., 2020). Mental health research further indicates that administrative demands and performance management can distort coordination's purpose, contributing to divergence between policy expectations and enacted practice (Hannigan et al., 2018).

System-level outcomes

Within the available evidence, the most frequently measured system-level outcomes associated with nurse-led coordination are emergency department presentations/visits, hospitalizations/readmissions, and referral patterns. Coordinated primary care programs report reductions in ED presentations and time in ED alongside increased community referrals, consistent with a mechanism of shifting utilization from acute to planned community care (Mallitt et al., 2016). Transitional care synthesis reports improvements in 30-day all-cause readmission rates across implementation studies of transitional care models (Chakurian & Popejoy, 2021; Allen et al., 2020). Nonetheless, higher-level synthesis cautions that effects on hospitalizations and ED visits are inconsistent across studies, with some evidence suggesting that intensity, targeting of specific risk factors, and multidisciplinary plans may be important determinants of effectiveness (Conway et al., 2017; Duan-Porter et al., 2021). Consequently, system-level endpoints are salient but contingent on context and implementation.

Evidence strength for pathways and mechanisms

The evidence base supports associative and mechanism-informed pathways more strongly than universal causal claims. Conceptual and measurement appraisals suggest association between continuity/coordination factors and outcomes while noting incomplete consensus and variability (Weaver et al., 2017). Systematic review evidence indicates inconsistent effects of nurse care coordination across studies, while suggesting that certain components frequent contact, ongoing monitoring, transitional care elements, and behavior-change principles are more likely to be present in higher-quality studies that report improved outcomes, implying component-linked inferential pathways (Conway et al., 2017; Duan-Porter et al., 2021). Realist approaches strengthen explanatory linkage by specifying context mechanism outcome configurations and highlighting the

role of implementation fidelity; low fidelity can weaken mechanism activation and outcome evidence (Harris et al., 2019). Mechanism-focused synthesis on fragmented care prevention and medication management further emphasises that favorable outcomes often depend on role clarity, structured workflows, education, and technological infrastructure, reinforcing that domain outcome linkages are context dependent rather than universally causal (Sumpter et al., 2022).

The Taxonomy as a Structured Results Output

Integrating the evidence-derived activity clusters, continuum categorisation, partnership requirements, tool infrastructure, and outcome linkages, the study's taxonomy comprises ten strategy domains (see Table 1) that collectively operationalize advanced nurse led care coordination. The taxonomy is designed to translate recurring coordination functions into implementable domains with identifiable steps, partners, tools, and outcomes, thereby supporting comparative synthesis and future empirical evaluation.

This study advances the nurse-led care coordination literature by presenting a multi-domain taxonomy that consolidates recurring advanced nursing coordination activities into an operational framework spanning the continuum of care. The taxonomy is broadly consonant with transitional care and chronic care models in its fundamental problem framing: contemporary systems are characterized by fragmentation that disrupts pathways and elevates risks at interfaces between providers, settings, and sectors (Nabelsi & Plouffe, 2024; Sobis, 2023). Transitional care scholarship foregrounds communication and coordination during high-vulnerability transitions, particularly hospital-to-home, emphasizing practices such as team discussion, discharge questioning, and engagement of patients and carers to ensure safe and integrated transitions (Allen et al., 2020; Magagnin et al., 2022). Chronic care reform framings likewise position coordination as essential for people with multimorbidity by emphasizing tailored, coordinated care plans that connect medical, nursing, allied health, and out-of-hospital services, often with a nominated clinician responsible for coordination (Lowe, 2017; Davis et al., 2019). These convergences indicate that the taxonomy's explicit representation of communication, linkage, and continuity mechanisms aligns with the conceptual core of both transitional and chronic care paradigms (Lowe, 2017).

A key contribution of the multi-domain taxonomy is its temporal completeness across the care continuum. Transitional care models are frequently concentrated in the peri-discharge window, and synthesis work suggests that model activities are often dominated by communication and do not substantially extend beyond the immediate post-discharge period, which may limit their fit for long-term chronic disease management (Chakurian & Popejoy, 2021). In contrast, chronic care models are intrinsically longitudinal and depend on sustained follow-up and continuity mechanisms for people with complex conditions (Lowe, 2017; Davis et al., 2019). By structuring coordination across assessment, planning, transition, monitoring, and evaluation, the taxonomy can be interpreted as a bridging scaffold: it preserves transitional care's emphasis on transition-point vulnerability and information exchange while systematically incorporating longitudinal domains that more directly address multimorbidity and ongoing continuity needs (Allen et al., 2020; Conway et al., 2017). This integration is particularly important because fragmentation risk is

not confined to discharge episodes but persists across repeated encounters, referrals, and evolving needs over time.

A second differentiator is the taxonomy's capacity to make accountability and role ownership explicit domains that existing models sometimes under-specify. Transitional care synthesis using the Care Coordination Atlas has noted that while communication dominates transitional care activities, accountability/responsibility may not be addressed as an explicit domain (Chakurian & Popejoy, 2021). This omission is consequential because empirical evidence demonstrates that ambiguous coordination ownership and weak communication can shift coordination burdens to patients and relatives. In palliative home care, unclear identification of the "key coordinator" role and lack of communication between team members generate conflicting understandings of responsibility and can result in family overburden without adequate support (Reeves et al., 2020). Similar concerns about heterogeneity and role ambiguity motivate oncology coordination research that seeks a reference framework to guide standardization and evaluation of care coordination nursing occupations (Colombani et al., 2019). In this context, the taxonomy's operational requirements explicit delineation of tasks, interfaces, and escalation responsibility across domains should be understood not merely as descriptive detail but as a governance mechanism that can reduce role drift and unmanaged task shifting (Anderson & Hewner, 2021; Reeves et al., 2020; Hannigan et al., 2018).

The taxonomy is also compatible with person-centred coordinated care perspectives that emphasize coordination as experienced through an individual's journey over time, rather than as a set of administrative transactions. Action research and narrative-based work argues that definitions and descriptors of coordination should integrate service users' expectations and subjective experiences, especially in fragmented systems where conventional frameworks may insufficiently reflect what matters to patients and carers (Phelan et al., 2021; Schor, 2019). A multi-domain structure can help specify where person-centredness is operationalized for example, through co-designed shared care plans in the planning domain, active engagement of patients and carers during transitions, and monitoring aligned with patient priorities and barriers. However, the literature also cautions that person-centred care is constrained by organisational, regional, and sociocultural determinants such as staffing capacity, translation gaps, discrimination, and regional coordination deficits, implying that a taxonomy must be implemented with contextual annotation rather than assumed to operate uniformly across settings (Hannigan et al., 2018). In practical terms, this means that the taxonomy should function as a structured hypothesis about what coordination work should entail, while permitting adaptation to local constraints and equity needs.

Explicit operationalization of advanced nurse roles is likely to add value for implementation and policy by improving standardization, replicability, and evaluability of nurse-led coordination. Nursing concept analysis documents persistent lack of role clarity in care coordination, limiting consistent implementation and measurement (Anderson & Hewner, 2021). Parallel arguments appear in the "nurse-led services" and nurse-led model literature, where inconsistent definitions hinder comparability and effectiveness of implemented models (Khair & Chaplin, 2017; Clarke et al., 2024). By specifying domains, tasks, boundaries, and commonly used artefacts and tools, a taxonomy can provide a definitional basis for program design, competency expectations, and monitoring. It also supports governance and accountability by clarifying responsibility and

preventing coordination work from becoming either administratively distorted or informally displaced onto families. This is particularly salient given evidence that care coordination “as imagined” in policy can diverge from care coordination “as done” in practice under administrative performance pressures and resource scarcity (Hannigan et al., 2018). Thus, operationalization can protect coordination’s relational and clinical purpose by making critical work visible and legitimate within performance and accountability systems.

From a workforce and education perspective, the taxonomy can be translated into competency frameworks, staffing models, and training curricula. Systematic review evidence suggests that favorable outcomes are more likely when nurse coordination includes frequent contact, ongoing follow-up and monitoring, transitional care components, and behavior-change principles, implying that these elements represent candidate core competencies to be developed and supported through staffing and training (Conway et al., 2017). The concept of “systems of communication” as an essential attribute of nurse-led coordination further indicates that training must include domain-specific skills in documentation, consented information sharing, interprofessional communication, and role delineation (Baker et al., 2022; Baker et al., 2016). Cross-system coordination studies also imply that clinical training alone is insufficient: coordinators may require capability in administrative navigation, eligibility processes, and inter-institutional referral pathways, particularly in contexts where services span distinct governance systems (Howren et al., 2021; Maguire et al., 2022). At the service redesign level, the taxonomy offers a common language to clarify interfaces, reduce duplication, and embed evaluation and learning loops. Evidence that transitional models may under-address accountability suggests redesign opportunities to assign ownership for each domain and ensure handoffs include responsibility transfer, not only information exchange (Chakurian & Popejoy, 2021; Anderson & Hewner, 2021). Action research models further demonstrate that coordination frameworks should embed iterative evaluation cycles to refine workflows and improve fit over time (Davis et al., 2019).

Nonetheless, application of a taxonomy across health systems is constrained by structural and evidence limitations. Cross-national research identifies that coordination is shaped by funding arrangements, management structures, electronic record systems, and organisational boundaries, implying that the same domain may require different enabling mechanisms across jurisdictions (Nystrom et al., 2024). In older-person care, decentralization, local autonomy, and regulatory arrangements can impede integration and sustain coordination problems despite repeated reforms (Sobis, 2023). Digital infrastructure can strengthen coordination through secure information transmission and shared visibility of follow-up needs, but it also introduces information governance constraints; confidentiality research highlights the necessity of privacy frameworks, access controls, and data sharing agreements, indicating that taxonomy enactment depends on regulatory compatibility and interoperability (Nabelsi & Plouffe, 2024; Ibrahim et al., 2024). Finally, the broader evidence base shows mixed effects of coordination interventions on patient experience and utilization outcomes, with substantial heterogeneity in components, intensity, and implementation fidelity (Conway et al., 2017; Duan-Porter et al., 2021). These findings support cautious interpretation: the taxonomy should be treated as an implementation hypothesis to be tested through robust evaluation designs that incorporate context and fidelity monitoring (Palmer et al., 2019; Ginsburg et al., 2021). Within these constraints, a multi-domain taxonomy remains

valuable as a structured scaffold that integrates transitional and chronic care coordination logics, makes accountability and communication infrastructures explicit, and provides a practical basis for workforce development, program governance, and comparative research across complex care settings.

CONCLUSION

This study developed a multi-domain taxonomy to structure advanced nurse led care coordination for people with complex and chronic conditions. The taxonomy consolidates recurring coordination practices into an operational framework that spans the continuum of care and specifies what coordination entails in practice namely, how patients are identified and assessed, how plans are co-designed and shared, how transitions are managed, how longitudinal monitoring is sustained, and how outcomes are evaluated and used for continuous improvement.

The central contribution of the taxonomy is its ability to integrate coordination work that is often described in fragmented or program-specific terms into a coherent set of domains with explicit operational elements. By linking each domain to implementation steps, interprofessional partnerships, commonly used artefacts and tools, and targeted outcomes, the taxonomy clarifies the advanced nurse role as an orchestrator of continuity across settings and sectors. In doing so, it addresses persistent challenges in the literature regarding definitional inconsistency, role ambiguity, and under-specified accountability, which have historically constrained replication, comparative evaluation, and policy translation.

The taxonomy also provides a practical blueprint for service design and improvement. For practice and service redesign, it offers a structured way to assign responsibility, standardize communication routines, reduce duplication, and ensure that high-risk periods particularly transitions receive intensified coordination. For workforce development and education, it translates “coordination” into discrete competency areas (e.g., multidimensional assessment, shared care planning, structured handover, navigation, patient coaching, and data-informed quality improvement) that can be incorporated into role descriptions, training curricula, and supervision frameworks. For policy, it supplies definitional clarity that can support scope-of-practice decisions, governance arrangements, and the alignment of financing and accountability with real coordination tasks.

At the same time, the taxonomy should be applied with attention to context. Differences in funding, governance, information infrastructure, workforce capacity, and digital privacy requirements shape how coordination domains can be operationalized across health systems. Moreover, given the heterogeneity and mixed outcome effects reported in coordination intervention evidence, the taxonomy is best treated as an implementation hypothesis that should be tested, adapted, and refined through empirical evaluation, including fidelity and process assessment.

In summary, the proposed taxonomy advances both conceptual clarity and practical usability in advanced nurse led care coordination. It offers a foundation for standardized program development and comparative research, while providing a structured pathway to improve

continuity, patient experience, and system performance for individuals living with chronic illness and multimorbidity.

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