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Impact of Value-Based Payment and Alternative Payment Models on Nursing Practice Autonomy, Documentation Burden, and Care Coordination Quality in Ambulatory and Transitional Care Settings

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Abstract

Value-based payment (VBP) and alternative payment models (APMs) are reshaping healthcare financing by linking reimbursement to quality, efficiency, patient experience, and population health. These reforms have particular implications for nursing in ambulatory and transitional care, where outcomes depend on longitudinal relationships, timely follow-up, and coordination across organizations. This narrative review examines how accountable care organizations, bundled payments, capitation, shared savings, and pay-for-performance arrangements may influence nursing autonomy, documentation burden, and care coordination quality. The literature suggests that appropriately designed payment reforms can create opportunities for nurse-led care management, expanded clinical decision-making, and investment in continuity services. However, performance monitoring, fragmented electronic records, and duplicated reporting can intensify administrative work and constrain professional discretion. Effects are mediated by staffing, scope-of-practice regulation, leadership, risk adjustment, and digital infrastructure. Sustainable value-based care therefore requires nursing representation in governance, payment recognition for coordination activities, streamlined documentation, and balanced measures that capture both patient outcomes and nursing work conditions.

Keywords: value-based payment; alternative payment models; nursing autonomy; documentation burden; care coordination.

Introduction

Healthcare financing has progressively moved from payment for discrete services toward arrangements that reward quality, outcomes, and the efficient use of resources. Fee-for-service (FFS) reimbursement pays for the volume of services delivered and may inadequately recognize prevention, longitudinal management, patient navigation, and communication between providers. VBP seeks to align financial incentives with quality and value, while APMs provide the contractual mechanisms through which these goals are pursued. Common models include pay-for-performance, bundled or episode-based payments, capitation, global budgets, accountable care organizations (ACOs), and shared-savings or shared-risk arrangements. The evidence base shows that the design of these models and the service-delivery reforms accompanying them matter as much as the label attached to a payment contract (Cattel & Eijkenaar, 2020; Howard et al., 2024; Simmons et al., 2024).

Nursing is central to the implementation of value-oriented care. In ambulatory settings, registered nurses and advanced practice registered nurses assess patients, monitor chronic conditions, deliver preventive education, manage telephone triage,

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reconcile medications, and coordinate referrals. In transitional care, nurses help patients move safely from hospital to home, rehabilitation, or community services. Their work frequently includes activities that are essential to outcomes but are not separately reimbursed under traditional FFS arrangements. Erikson et al. (2017) found that health systems participating in new payment models were investing in care-coordination workforces and redistributing tasks across registered nurses, practical nurses, medical assistants, and other staff. Longyear and Mills (2024) similarly argued that alternative reimbursement approaches may better recognize nursing contributions to staffing and patient care.

The effects of payment reform on nursing are not uniformly positive. Financial incentives may encourage investment in care management and nurse-led services, but they may also create stronger performance surveillance, narrow targets, productivity expectations, and documentation requirements. This review focuses on three connected dimensions: professional autonomy, documentation burden, and care coordination quality. Autonomy concerns nurses' ability to exercise clinical judgment and participate in decisions within their scope of practice. Documentation burden concerns the time and cognitive effort required to record care and satisfy clinical, administrative, and reporting obligations. Care coordination quality concerns the organization of services and information across clinicians, organizations, and care settings.

The three dimensions are especially relevant in ambulatory and transitional care. Patients with multimorbidity often need repeated monitoring and support between visits, while transitions after hospitalization involve risks of medication discrepancies, incomplete information transfer, missed follow-up, and preventable acute-care use. Comprehensive transitional care depends on patient and caregiver engagement, cross-setting communication, and timely follow-up (Naylor et al., 2017; Tyler et al., 2023). However, evidence linking payment design directly to nursing outcomes remains less developed than evidence on organizational spending and utilization. The review therefore distinguishes direct nursing evidence from broader health-system evidence and avoids treating association as proof of causation.

2. Aim and Review Questions

The aim of this narrative review is to critically examine the implications of VBP and APMs for nursing practice autonomy, documentation burden, and care coordination quality in ambulatory and transitional care settings. The review addresses four questions: (1) how do alternative payment arrangements change the organizational expectations placed on nurses; (2) under what conditions do these arrangements expand or constrain professional autonomy; (3) how do performance measurement and electronic documentation influence nursing workload; and (4) how can nursing-led coordination contribute to continuity, patient experience, and reduced avoidable utilization?

3. Review Method

A narrative review approach was used to integrate empirical studies, systematic and scoping reviews, policy analyses, and conceptual publications relevant to payment reform and nursing practice. The literature window was restricted to 2017–2024. The review scope included PubMed/MEDLINE, CINAHL, Scopus, Web of Science, and Google Scholar, with supplementary searches of policy and professional sources. Search concepts combined terms for value-based payment, alternative payment models, ACOs, bundled payments, capitation, shared savings, nursing autonomy, nurse practitioners, electronic health records, documentation burden, ambulatory care, transitional care, and care coordination.

Publications were considered relevant when they addressed at least one of the three focal nursing dimensions or provided important evidence about payment design and service-delivery changes that shape those dimensions. Research in multidisciplinary teams was included when findings were relevant to nursing roles, documentation, or coordination. Studies outside the 2017–2024 period were not used as core evidence. Because this is a narrative review, it does not claim exhaustive retrieval, duplicate independent screening, formal risk-of-bias grading, or meta-analysis. The synthesis is interpretive and should not be read as a systematic estimate of causal effects.

4. Overview of Value-Based Payment and Alternative Payment Models

4.1 From volume to value

FFS reimbursement can reward additional visits, procedures, and tests without necessarily rewarding the work needed to prevent deterioration or coordinate care across settings. VBP attempts to address this limitation by linking payment to selected quality, cost, patient-experience, or population-health outcomes. In practice, VBP is not one model: it encompasses different degrees of financial risk, prospective funding, quality bonuses, and accountability for total cost of care. Howard et al. (2024) describe APM development as a process requiring deliberate alignment of incentives, quality measurement, care management, and implementation capacity. Simmons et al. (2024) found that population-based payment models may be better suited to person-centered care spanning providers and settings, but that payment and service-delivery reforms are often implemented simultaneously, complicating attribution.

Pay-for-performance (P4P) programs link bonuses or penalties to specified indicators such as preventive screening, chronic disease monitoring, immunization,

or patient experience. Bundled payments provide a predetermined amount for an episode of care, encouraging coordination among providers involved in that episode. Capitation and global budgets provide prospective payments for an enrolled or attributed population, potentially supporting prevention and longitudinal care. ACOs make groups of providers collectively accountable for quality and spending, with shared savings and, in some arrangements, shared losses. Each model creates distinct incentives and risks; therefore, their effects on nursing cannot be assumed to be interchangeable.

4.2 Organizational mechanisms and nursing work

Payment models affect nursing through organizational decisions about workforce deployment, care-management infrastructure, performance metrics, technology, and service design. A prospective population payment may make it financially attractive to invest in nurse care managers and proactive outreach, while an episode-based contract may increase attention to discharge preparation and post-discharge contact. Erikson et al. (2017) observed strategic changes in coordination staffing under payment reform, including task shifting and training needs. Evidence from ACO research also indicates that changes in utilization and care processes are variable and depend on program design and organizational context (Kaufman et al., 2019; Bleser et al., 2019).

Payment reform does not itself create integrated care. Organizations need leadership, adequate staffing, reliable data, and clearly allocated responsibilities. The implementation literature emphasizes stakeholder engagement, transparent incentives, and readiness to change workflows (Leao et al., 2023a, 2023b). Where payment contracts are introduced without corresponding resources, nurses may be held accountable for targets they cannot control. Where investment and governance are aligned, the same reforms may create new opportunities for clinical leadership and continuity work. Figure 2 illustrates the pathways through which value-based payment influences nursing practice.



Figure 2. Pathways through which value-based payment influences nursing practice

5. Nursing Practice Autonomy

5.1 Meaning and dimensions of autonomy

Nursing autonomy is the capacity to apply professional knowledge, clinical judgment, and accountability in decisions within the nurse's education, competence, legal scope, and organizational role. It does not mean working in isolation from other professionals. Rather, it combines independent judgment with collaboration and shared accountability. For nurse practitioners, autonomy also concerns the ability to practice to the extent of advanced education and training without unnecessary regulatory or institutional restrictions. Peacock and Hernandez (2020) clarify that autonomy should be distinguished from full practice authority, while Park et al. (2018) demonstrate that regulatory arrangements are related to day-to-day NP autonomy, although organizational and workplace factors also matter.

In ambulatory care, autonomy may involve comprehensive assessment, triage, patient education, monitoring of chronic illness, protocol-based treatment adjustment, and escalation of concerns. In transitional care, it may involve identifying discharge risks, coordinating medication reconciliation, arranging follow-up, and responding to emerging symptoms. Autonomy is therefore not simply a professional attitude; it depends on authority, access to information, staffing, interprofessional trust, and the ability to act on clinical assessments.

5.2 Potential for expanded nursing roles

Population-based payment may strengthen the business case for nursing activities that prevent complications and reduce avoidable utilization. Organizations may employ nurse care managers to identify high-risk patients, close preventive-care gaps, monitor treatment adherence, and coordinate services. Nurse-led chronic disease management is feasible and acceptable in primary care when roles, training, and organizational support are clearly defined (Stephen et al., 2018). Nurse care coordination may also improve patient-reported and health-service outcomes, although intervention components and contexts vary (Conway et al., 2019).

Advanced practice nurses can contribute to access and quality when professional authority is aligned with education and competence. A systematic review found that expanded NP practice regulations were associated with greater NP supply and improved access among rural and underserved populations without evidence of reduced care quality (Yang et al., 2020). These findings support the proposition that payment reform is more likely to translate into meaningful nursing autonomy when accompanied by enabling regulation. ACO research has also explored the contribution of NP participation to selected quality and utilization outcomes, although organizational associations should not be interpreted as direct causal proof (Huang et al., 2021).

The patient-centered medical home (PCMH) offers a related example of ambulatory redesign. PCMH transformation may change teamwork, professional experience, and quality processes, but the consequences for staff depend on implementation and local context (Fortuna et al., 2021). Evaluations of PCMH initiatives have found variation in quality and utilization effects, cautioning against assuming that

recognition or transformation alone guarantees better outcomes (Shippee et al., 2018; Marsteller et al., 2018; Flieger, 2017). These findings are relevant to VBP because PCMH structures are frequently paired with payment incentives and care-management functions.

5.3 Risks to autonomy

The same accountability mechanisms that support role expansion can constrain discretion. Organizations under shared-risk contracts may introduce utilization targets, standardized pathways, referral controls, and productivity benchmarks. Standardization can reduce unwarranted variation and support safety, but it can also become restrictive when protocols do not accommodate patient complexity or clinical uncertainty. Nurses may experience pressure to prioritize measurable indicators over less easily quantified needs, including psychosocial assessment, caregiver support, and shared decision-making.

Autonomy can also be undermined when responsibility is delegated without authority. A nurse may be expected to reduce readmissions but lack timely access to discharge summaries, authority to adjust follow-up plans, or sufficient staffing for outreach. Task shifting may free registered nurses for complex cases, but it requires training, supervision, and clear escalation pathways (Erikson et al., 2017). Nurse-led services similarly require organizational recognition and operational support rather than being treated merely as low-cost substitutes for other services (Terry et al., 2024).

5.4 Governance and professional voice

Nursing participation in payment-model governance is necessary to ensure that performance indicators reflect clinical realities. Nurses should participate in selecting quality measures, designing care pathways, reviewing staffing plans, and evaluating documentation systems. When nursing leaders are excluded, measures may inadvertently create additional work or fail to capture the contribution of relational and coordination activities. Professional voice also supports ethical safeguards: cost reduction must not override clinically indicated care, informed patient choice, or equitable access.

6. Documentation Burden and Digital Accountability

6.1 Why documentation expands under VBP

Documentation supports safe care, communication, continuity, legal accountability, and quality improvement. Under VBP, it also becomes a means of demonstrating that required processes occurred and that performance targets were achieved. Nurses may need to document screening, medication reconciliation, education, follow-up, risk stratification, and care-plan updates. These activities are clinically relevant, but reporting demands can become burdensome when the same information is entered into multiple systems or when performance fields are added without workflow redesign.

The documentation burden literature shows that this construct is multidimensional. Moy et al. (2021) identified EHR workload, after-hours work, administrative tasks, workflow fragmentation, and reduced patient interaction as relevant measurement dimensions. Wang et al. (2024) expanded the measurement landscape and found that documentation burden has been assessed using EHR logs, time measures, usability measures, and other indicators, while validity and comparability remain incomplete. Thus, counting notes or mandatory fields alone does not adequately capture burden.

6.2 EHR usability and nursing workload

Electronic records can improve information availability and standardization, but they can also introduce additional steps, repeated data entry, alerts, and fragmented workflows. A longitudinal study of nursing workload indicators after EHR implementation found increases in several measures of EHR activity and documentation time (Martín-Méndez et al., 2021). Community nurses have also described relationships between documentation activities and perceived workload, with distinctions between clinical and organizational documentation (De Groot et al., 2022). Research on clinical documentation among nurses and midwives further illustrates the need to distinguish perceived burden from measured time (Cooper et al., 2021).

EHR burden is influenced by usability and configuration. Lindsay et al. (2022) describe workflow redesign and documentation optimization as practical strategies for aligning electronic fields with clinical processes. Alobayli et al. (2023) used mixed methods to examine nurses' EHR use and documentation burden, while Khan et al. (2022) reported that system usability and the organization of EHR tasks remain important areas for improvement. These studies are not direct evaluations of VBP, but they are relevant because value contracts frequently increase dependence on electronic performance data.

6.3 Risks of metric-driven documentation

A performance measure can generate unintended documentation work when it is not integrated into routine clinical recording. A nurse may record a clinical intervention in the narrative note and then repeat it in a quality registry or separate reporting tool. Such duplication consumes time, increases inconsistency risk, and may divert attention from patient communication. Documentation also has cognitive costs: nurses must decide which fields are relevant, reconcile conflicting information, and navigate screens while maintaining awareness of the patient's clinical condition.

A further risk is that documentation completion becomes a proxy for care quality. Complete records are important, but they do not guarantee that the

patient understood the education, obtained the medication, attended follow-up, or received an effective referral. Organizations should therefore distinguish the existence of a documented process from evidence that the process achieved its intended result.

6.4 Strategies to reduce burden without weakening accountability

The most defensible response is not to reduce clinically necessary documentation indiscriminately, but to remove duplication and improve usability. Organizations should map nursing workflows before adding reporting requirements; integrate quality indicators into the primary EHR; use structured fields only where they add clinical or analytical value; automate extraction of data already captured; and periodically retire low-value fields. Nurses should participate in template design and usability testing. Measures should include time spent in the EHR, after-hours activity, duplication, interruptions, usability, and time available for patient interaction. Documentation optimization projects should also assess accuracy and patient-safety consequences rather than focusing solely on speed.

7. Care Coordination Quality in Ambulatory and Transitional Settings

7.1 Care coordination and value

Care coordination is the deliberate organization of patient-care activities and information among multiple participants to facilitate appropriate and continuous services. It includes shared care planning, communication, referral management, medication reconciliation, patient education, and follow-up. Population-based payment models are conceptually aligned with these activities because they make organizations more accountable for outcomes across providers and settings. However, the evidence indicates that payment reforms and delivery reforms are often introduced together, making it difficult to isolate the contribution of financing itself (Simmons et al., 2024).

Care-coordination workforce investments under APMs may involve task shifting, nurse care management, and new training requirements (Erikson et al., 2017). ACO participation has been associated with changes in utilization and care processes, but systematic reviews describe heterogeneous effects and substantial variation across programs (Kaufman et al., 2019). Care-management intensity and coordination practices may also relate to organizational participation and performance, although findings should be interpreted with attention to selection and confounding (Bleser et al., 2019; Ouayogodé et al., 2019). Figure 1 summarizes the conceptual pathway linking payment reform to nursing practice outcomes.

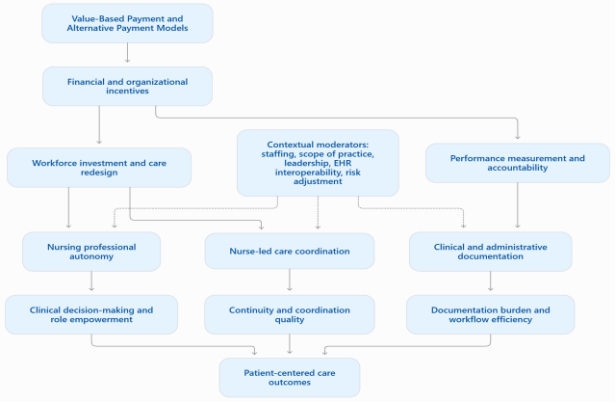

Figure 1. Conceptual pathway linking payment reform to nursing practice outcomes

7.2 Ambulatory nursing coordination

Ambulatory nurses coordinate care over time rather than within a single encounter. Their activities include identifying uncontrolled chronic conditions, reviewing test results, arranging referrals, supporting adherence, providing self-management education, and connecting patients with community resources. Nurse-led chronic disease interventions can be feasible and acceptable in primary care, but successful implementation requires clear role definition, training, and integration with the wider team (Stephen et al., 2018). Nurse care coordinator roles have been evaluated across patient-reported and health-service outcomes, with evidence suggesting potential benefits but variation in role design and study quality (Conway et al., 2019).

Payment arrangements may support these activities by funding care managers, registries, and outreach systems. However, the workforce design matters. Low-complexity coordination tasks can be allocated to trained support personnel, while registered nurses retain responsibility for complex assessment, clinical judgment, and escalation. This requires explicit competency frameworks and supervision. Without them, task shifting may create fragmented accountability or expose patients to inconsistent advice.

7.3 Transitional care and post-discharge continuity

Transitions from hospital to home or community care are high-risk periods. Patients may receive incomplete instructions, experience medication discrepancies, or fail to obtain timely follow-up. Transitional care interventions commonly combine discharge preparation, patient and caregiver education, medication reconciliation, telephone follow-up, home visits, and communication with primary care. Naylor et al. (2017) describe core components of comprehensive transitional care, emphasizing continuity and individualized support.

The evidence supports structured transitional care, although effects differ by intervention complexity and outcome. A network meta-analysis of 126 trials found that low- and medium-complexity interventions were

associated with reductions in readmission at selected time points, while different intervention intensities affected other outcomes differently (Tyler et al., 2023). Transitional care for older long-term-care residents has also been associated with reduced hospital or emergency readmissions, although the evidence base remains limited (Birtwell et al., 2022). These findings suggest that well-designed coordination can improve continuity, but more intensive programs are not necessarily superior in every context.

Nursing contributions include early discharge-risk identification, medication reconciliation, assessment of patient understanding, coordination with community services, and follow-up after discharge. These tasks require access to timely discharge information and the authority to escalate unresolved problems. Bundled payments may focus attention on episode costs and readmissions, while ACOs and capitation may encourage longer-term population management. In either case, the model should finance coordination work rather than assume that it can be absorbed into existing workloads.

7.4 Interprofessional collaboration and information exchange

Effective coordination requires shared responsibility among nurses, physicians, pharmacists, social workers, rehabilitation professionals, and community providers. Nurses often serve as communication links between patients and the wider team. Their effectiveness depends on clear pathways, interoperable records, shared care plans, and timely access to clinical advice. Payment incentives can encourage collaboration, but they cannot substitute for trust, role clarity, and reliable communication. A care pathway that rewards a completed referral should also measure whether the referral was received, acted upon, and communicated back to the referring team.

8. Comparative Implications of Payment Models

The implications of different APMs for nursing are summarized in Table 1. P4P can focus attention on defined quality processes, but narrow metrics may encourage task-oriented documentation. Bundled payments may strengthen coordination during a defined episode, but can create cost pressure if transitional-care resources are inadequate. Capitation and global budgets may support longitudinal nursing services, but risk adjustment is essential to avoid incentives to underserve patients with complex needs. ACOs can support population-health management and team-based care, while shared-risk arrangements may intensify pressure to control utilization. These effects are conditional, not inevitable, and depend on contractual details and organizational implementation (Cattel & Eijkenaar, 2020; Howard et al., 2024; Simmons et al., 2024).

Table 1. Comparative implications of alternative payment models for nursing practice

Payment model	Potential nursing opportunities	Potential risks	Practice implications
Pay-for-performance	Preventive screening, chronic disease monitoring, quality improvement	Narrow targets; added reporting; task prioritization	Use balanced measures and integrate documentation into routine workflow
Bundled payment	Discharge planning, patient education, post-discharge follow-up	Episode cost pressure; underfunded coordination	Protect transition staffing and define cross-setting responsibilities
Capitation/global budget	Longitudinal management, prevention, population health	Under-service risk; inadequate risk adjustment	Adjust for complexity and fund proactive nursing care
ACOs/shared savings	Nurse care management, team-based coordination, risk stratification	Uneven authority; performance surveillance	Include nurses in governance and share savings with care teams
Two-sided risk	Investment in avoiding preventable utilization and improving continuity	Strong financial pressure; possible restriction of needed services	Use clinical safeguards and monitor equity and patient experience

9. Interrelationships among Autonomy, Documentation, and Coordination

The three focal dimensions should be understood as a connected system. Professional autonomy can strengthen coordination when nurses are empowered to assess needs, initiate appropriate follow-up, and communicate with other providers. Documentation can support that coordination by making information visible and traceable. Conversely, duplicated documentation can reduce the time available for communication and patient education. If coordination failures occur, additional documentation and follow-up tasks may be generated, potentially creating a cycle of administrative expansion.

A positive cycle is also possible. When organizations give nurses decision-making authority and provide interoperable records, documentation can become a

useful clinical resource rather than a separate administrative burden. Better information exchange can reduce repeated histories, support medication reconciliation, and enable proactive follow-up. The key is not simply the volume of data collected, but whether information is accurate, accessible, actionable, and connected to clinical decisions.

10. Nursing-Sensitive Evaluation Framework

Traditional evaluations of APMs often emphasize total spending, readmission rates, and selected quality measures. These outcomes are important but insufficient to explain how payment reform changes nursing practice. A balanced framework should include structural measures, process measures, professional outcomes, and patient-centered outcomes. Structural measures include staffing, role mix, training, and EHR interoperability. Process measures include medication reconciliation, completed follow-up, referral closure, and documented patient education. Professional outcomes include perceived autonomy, participation in governance, workload, and job satisfaction. Patient outcomes include continuity, safety, experience, and equity.

Table 2. Proposed nursing-sensitive indicators for evaluating VBP implementation

Domain	Indicator	Suggested measurement	Intended interpretation
Autonomy	Participation in governance	Nursing representation on payment and quality committees	Professional voice in implementation
Autonomy	Clinical decision-making discretion	Validated nurse-reported autonomy scale; scope-of-practice audit	Ability to exercise judgment within role
Autonomy	Nurse-led service capacity	Availability, staffing, and scope of nurse-led clinics or care management	Expansion of nursing contribution
Documentation	EHR time and after-hours activity	Audit logs and time-motion sampling	Administrative time and workflow impact
Documentation	Duplicate data entry	EHR field mapping and record audit	Redundant reporting burden
Documentation	Usability and workflow fit	Validated usability survey and frontline observation	System suitability for nursing work
Coordination	Timely post-discharge contact	Proportion contacted within specified interval	Continuity after discharge
Coordination	Medication reconciliation	Proportion of eligible transitions reconciled	Medication safety and information continuity
Coordination	Referral closure	Proportion of referrals completed and communicated back	Cross-provider coordination
Coordination	Patient-reported coordination	Validated patient experience measure	Patient perspective on continuity
Balancing	Equity and access	Stratified analysis by clinical and social risk	Detection of under-service or unequal outcomes

Note. These are proposed indicators, not a validated instrument. Operational definitions, denominators, time windows, and psychometric properties should be specified before use.

11. Discussion

The review indicates that APMs can create a more favorable environment for nursing activities that support prevention, chronic disease management, and transitions across settings. The strongest rationale is that prospective or population-based payment makes organizations more accountable for outcomes beyond the immediate encounter. This can support investments in nurse care managers and coordination staff, as observed in early case studies of payment reform (Erikson et al., 2017). However, the evidence also shows that payment and service-delivery reforms are commonly implemented together, limiting causal attribution (Simmons et al., 2024).

For autonomy, the central issue is whether expanded responsibilities are matched by authority and resources. Payment reform may elevate nursing's strategic importance, but a nurse who is accountable for follow-up without access to records, decision authority, or sufficient time does not experience meaningful autonomy. NP scope-of-practice evidence reinforces the importance of legal and regulatory conditions (Yang et al., 2020; Park et al., 2018). Organizational leadership should therefore treat autonomy as a practical capability supported by governance, role clarity, and interprofessional trust.

Documentation presents a paradox. VBP requires reliable data, and documentation is essential for demonstrating care processes. Yet excessive reporting can undermine the very coordination and patient engagement that value-based care seeks to improve. The evidence on documentation burden highlights inconsistent measurement and the need to capture time, workflow fragmentation, after-hours work, and usability rather than relying on note counts (Moy et al., 2021; Wang et al., 2024). Community nursing research further suggests that the relationship between documentation and perceived workload depends on the type and purpose of documentation (De Groot et al., 2022).

Care coordination is a plausible mechanism through which APMs can improve quality, especially in chronic and transitional care. Yet it should not be reduced to readmission avoidance. Coordination quality also includes patient understanding, medication safety, access to services, caregiver support, and continuity. Evidence from transitional-care trials suggests that lower- and medium-complexity interventions can be effective for selected outcomes, challenging the assumption that more elaborate programs are always superior (Tyler et al., 2023).

The practical implication is that payment reform should be evaluated as an organizational intervention with nursing-sensitive outcomes. Financial savings alone are not sufficient evidence of success if they are achieved through increased workload, reduced autonomy, or unmet patient needs. Equally, an increase in documentation completeness should not be interpreted as improved quality unless the information supports better care. Balanced evaluation should combine patient outcomes, professional experience, workload, and equity (Hassmiller & Wakefield, 2022).

11.1 Equity considerations

Patients with multimorbidity, disability, limited health literacy, unstable housing, transportation barriers, and inadequate social support often require more intensive coordination. If payment formulas inadequately adjust for clinical and social complexity, organizations may face incentives to avoid costly patients or limit services. Nursing teams are often well placed to identify social and practical barriers that are not captured by conventional clinical measures. Risk adjustment, equity monitoring, and access safeguards should therefore be incorporated into APM contracts.

11.2 Implications for international health systems

Much of the empirical literature on APMs and NP scope of practice comes from the United States. Transferability to other countries depends on financing structures, professional regulation, primary-care organization, and the availability of community services. In health systems where nursing scope is more restricted or EHR interoperability is limited, payment reform may require foundational investment before expected benefits can be realized. The principles of recognizing coordination, protecting clinical judgment, and reducing duplicative documentation are nevertheless relevant across settings.

12. Recommendations

12.1 For healthcare organizations

Organizations should include nurses in the design, implementation, and evaluation of payment contracts. New responsibilities should be accompanied by staffing, training, role clarity, and appropriate authority. Care-coordination work should be mapped across the patient journey to identify gaps and duplication. EHR workflows should be reviewed before adding new quality-reporting fields, and redundant data entry should be removed wherever possible.

12.2 For nursing leaders

Nursing leaders should advocate for balanced performance dashboards that include autonomy, workload, coordination, patient experience, and equity. They should monitor after-hours documentation, staffing adequacy, and time available for direct care. Leadership development should include healthcare financing, population health, informatics, quality improvement, and negotiation of interprofessional roles.

12.3 For policymakers and payers

Payers should recognize nursing activities such as care navigation, medication reconciliation, patient education, transitional follow-up, and chronic disease management. Payment models should include risk adjustment and safeguards against under-service. Quality indicators should be clinically meaningful and feasible to document. Financial accountability should not weaken professional scope of practice or access to clinically indicated services.

12.4 For nursing education

Nursing curricula should incorporate value-based healthcare, payment models, population health, care coordination, health informatics, and quality measurement. Nurses should understand how their work contributes to outcomes and how to use performance data for improvement without allowing metrics to replace individualized care.

13. Limitations

This narrative review has several limitations. It does not use a systematic-review protocol, duplicate screening, or formal risk-of-bias assessment. The included evidence is heterogeneous in payment model, setting, professional role, and outcome definition. Direct evidence on the effects of APMs on nurses' perceived autonomy and documentation burden is limited; some conclusions are therefore based on related evidence about scope of practice, EHR workload, and care coordination. Most payment-model research originates in the United States,

limiting generalizability to other financing and regulatory contexts. Finally, concurrent implementation of payment and service-delivery reforms makes causal attribution difficult.

14. Conclusion

VBP and APMs are reshaping healthcare delivery by increasing organizational accountability for quality, efficiency, patient experience, and population health. These reforms can create opportunities for nursing role expansion, nurse-led care management, and stronger coordination across ambulatory and transitional settings. Their benefits, however, depend on whether professional responsibilities are matched by clinical authority, adequate staffing, leadership participation, and appropriate financial recognition. Performance accountability can also increase documentation burden when reporting requirements are fragmented or duplicative. The central policy challenge is therefore to design payment and delivery systems that recognize nursing contributions while protecting professional autonomy and minimizing unnecessary administrative work. A nursing-sensitive approach to value-based care should measure not only spending and readmissions but also autonomy, documentation efficiency, continuity, patient experience, and equity.

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