

Care Coordination *and* Transition Management



CORE CURRICULUM

Editors

Sheila A. Haas, PhD, RN, FAAN
Beth Ann Swan, PhD, CRNP, FAAN
Traci S. Haynes, MSN, RN, CEN

Table of Contents

A Message from AAACN President	v
Foreword	vi
Preface	viii
Contributors	ix
Reviewers	xi
Expert Panels	xiii
Acknowledgments	xiv
Chapter 1	1
Introduction	
Chapter 2	13
Advocacy	
Chapter 3	23
Education and Engagement of Patients and Families	
Chapter 4	37
Coaching and Counseling of Patients and Families	
Chapter 5	47
Patient-Centered Care Planning	
Chapter 6	65
Support for Self-Management	
Chapter 7	77
Nursing Process (Proxy for Monitoring and Evaluation)	
Chapter 8	89
Teamwork and Collaboration	
Chapter 9	101
Cross-Setting Communications and Care Transitions	
Chapter 10	113
Population Health Management	
Chapter 11	141
Care Coordination and Transition Management (CCTM) Between Acute Care and Ambulatory Care	
Chapter 12	163
Informatics Nursing Practice	
Chapter 13	175
Telehealth Nursing Practice	
Glossary	189
Resources	199
AAACN Fact Sheet	201
Index	203

CHAPTER 1

Introduction

Beth Ann Swan, PhD, CRNP, FAAN

Sheila A. Haas, PhD, RN, FAAN

Traci S. Haynes, MSN, RN, CEN

I. Purpose

During the summer of 2011, the American Academy of Ambulatory Care Nursing (AAACN) Health Care Reform Advisory Team made a recommendation to the AAACN Board of Directors that there was a need for written competencies for the care coordination transition management (CCTM) registered nurse (RN) role. The Advisory Team worked with their Board Liaison and the Executive Team to develop a survey asking members if they had access to CCTM competencies, and if not, if they felt a need for competencies.

A nine-question survey link was sent to the AAACN membership in July 2011. Respondents were asked to complete the survey using an online survey tool. It was revealed that very few sites had access to CCTM competencies, and those that did had developed them internally. Most respondents also felt competencies needed to be evidence-based and more thorough to support the care provided to patients and their families. One member wrote, "Competency would create standardization and ensure excellence in the care we are providing." Another wrote, "They are needed because our work needs to be validated, supported, and replicated, and it needs to be evidence-based so we can provide the best quality of care." Other responses included: "I provide this type of care in a clinic setting. It is a huge part of the job and requires adequate time to do well. Yet staff is poorly oriented and trained in the skills and knowledge needed to provide this vital care. Measurable and defined competencies would support improvement in the delivery of care;" "Competencies help ensure that staff have the right level of training and knowledge which ultimately helps improve patient safety;" "From a quality perspective, competencies are always important to indicate performance and performance improvement opportunities;" "We need a system to help ensure consistency and standardization within an organization and amongst organizations;" "There is an increasing need for RN care coordination with the Medical Home initiative. This is not a skill that is taught in nursing schools or that is acquired while working in the hospital setting."

Based on feedback received from the membership, the AAACN Board of Directors made the decision to move forward in the development of the CCTM competencies. Two of AAACN's Health Care Reform Advisory Team members, Dr. Sheila Haas and Dr. Beth Ann Swan, agreed to co-chair this initiative while Ms. Traci Haynes served as the Board Liaison and Project Manager.

II. Vision for the *Core Curriculum* as the Foundation for the Care Coordination and Transition Management (CCTM) Model

A. Vision.

1. The Care Coordination Transition Management (CCTM) Model standardizes the work of ambulatory as well as acute, subacute, and home care health care providers using evidence from interdisciplinary literature on care coordination and transition management.
2. The CCTM Model.
 - a. Specifies the dimensions of care coordination and transition management and the associated competencies needed to be performed within the CCTM Model.
 - b. Defines the knowledge, skills, and attitudes needed for each dimension.
 - c. Meets the needs of patients with complex chronic illnesses (and their families) being cared for in Patient-Centered Medical Homes (PCMH), as well as traditional and nontraditional outpatient settings.
 - d. Recommends RNs educated and prepared to work as an RN in CCTM be recognized and reimbursed by Centers for Medicare & Medicaid Services (CMS).
3. Consistent with the mission and vision of the Quality and Safety in Nursing Education (QSEN) initiative (Cronenwett et al., 2007), nurses learning about the CCTM competencies and role will develop knowledge, skills, and attitudes requisite to competent practice within the nine CCTM dimensions/competencies. Each chapter of the *Care Coordination and Transition Management Core Curriculum* will include a Knowledge, Skills, and Attitudes table that summarizes behavioral expectations for each of the nine CCTM competencies.
4. Consistent with the Institute of Medicine's Report, *The Future of Nursing: Leading Change Advancing Health* (2010), the CCTM Model:
 - a. Supports RNs practicing to the full extent of their education and training.
 - b. Promotes RNs achieving higher levels of education, training, and licensure through an improved education system that promotes seamless academic progression.
 - c. Advocates that RNs are full partners, with physicians and other health care professionals, in redesigning health care in the United States.

- d. Highlights that effective workforce planning and policymaking require better data collection and an improved information infrastructure.
 - e. Expands opportunities for nurses to lead and diffuse collaborative improvement efforts.
 - f. Prepares and enables nurses to lead change to advance health.
5. Consistent with the American Nurses Association's (ANA) book, *Care Coordination: The Game Changer* (Lamb, 2014), care coordination models are vital for achieving quality and safety outcomes for patients and families (Haas & Swan, 2014).
 6. Consistent with the work of national professional organizations.
 - a. ANA's Position Statement on *Care Coordination and Registered Nurses' Essential Role* (2012a).
 - b. ANA's white paper *The Value of Nursing Care Coordination* (2012b).
 - c. ANA's *Framework for Measuring Nurses' Contributions to Care Coordination* (2013).
 - d. ANA's (2013) Care Coordination Quality Measures Panel.
 - e. American Academy of Nursing's (AAN) imperative for patient, family, and population-centered interprofessional approaches to care coordination and transitional care (2012).
 - f. AAN's summary of the importance of health information technology in care coordination and transitional care (Cipriano et al., 2013).

III. Definitions

- A. Competence and achievement of professional practice competencies have long been expected of professionals and long assumed to be present by consumers. It is interesting, however, that consistent definitions for both are not easy to find. The American Nurses Association in 2008 issued a Position Statement on Competence. It included Definitions and Concepts in Competence that state: "An individual who demonstrates 'competence' is performing successfully at an expected level. A 'competency' is an expected level of performance that integrates knowledge, skills, abilities, and judgement. The integration of knowledge, skills, abilities and judgement occurs in formal, informal and reflective learning experiences" (ANA, 2008, p. 2).
- B. Care coordination.
 1. Agency for Healthcare Research and Quality (AHRQ) definition: "Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care" (McDonald et al., 2011, p. 4; McDonald et al., 2007).
 2. National Quality Forum definition: "Care coordination is defined as an information-rich, patient-centric endeavor that seeks to deliver the right care (and only the right care) to the right patient at the right time...A function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions and sites are met over time...Care coordination maximizes the value of services delivered to patients by facilitating beneficial efficient, safe and high-quality patient experiences and improved health care outcomes" (NQF, 2010, p. 2).
- C. Transition management.
 1. "Transitional care is defined as a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another" (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011, p. 747).
 - a. Core features of transitional care include:
 - (1) Comprehensive assessment of an individual's health goals and preferences; physical, emotional, cognitive, and functional capacities and needs, and social and environmental considerations.
 - (2) Implementation of an evidence-based plan of transitional care.
 - (3) Care that is initiated at hospital admission, but extends beyond discharge through home and telephone visits.
 - (4) Mechanisms to gather and share information across sites of care.
 - (5) Engagement of patients and family caregivers in planning and executing the plan of care.
 - (6) Coordinated services during and following the hospitalization by a health care professional with special preparation in the care of chronically ill people, often a master's-prepared nurse (Naylor & Sochalski, 2010, p. 2).
 2. "Care transitions refer to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. For example, in the course of an acute exacerbation of an illness, a patient might receive care from a primary care physician or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might re-

turn home, where he or she would receive care from a visiting nurse. Each of these shifts from care providers and settings is defined as a care transition” (Coleman & Boulton, 2003, p. 556).

3. “Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, sub-acute and post-acute nursing facilities, the patient’s home, primary and specialty care offices, and long-term care facilities” (Coleman & Boulton, 2003, p. 556).
 - a. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient’s goals, preferences, and clinical status.
 - b. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition.
 - c. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs (Coleman & Boulton, 2003).
 4. The authors expand on these terms and definitions of transitional care and care transitions to the term *transition management*. The authors define *transition management* as the ongoing support of patients and their families over time as they navigate care and relationships among more than one provider and/or more than one health care setting and/or more than one health care service. The need for transition management is not determined by age, time, place, or health care condition, but rather by patients’ and/or families’ needs for support for ongoing, longitudinal individualized plans of care and follow-up plans of care within the context of health care delivery
- D. Care coordination and transition management.
1. In the setting, care coordination and transition management are integrated functions that may occur simultaneously or separately and are not time limited as defined above. One provision of the Patient Protection and Affordable Care Act (2010) to support this expanded definition is the need for individualized plans of care and follow-up plans of care that move with patients longitudinally over time.
 2. Individualized plans of care and follow-up plans of care serve as the basis for the CCTM Model, an innovative patient-centered interprofessional collaborative practice care delivery model that integrates the RN role as care coordinator and transition manager (Swan & Haas, 2011).
 3. CCTM Model acknowledges the care coordination

and transitional care activities performed by RNs and interprofessional team members in acute care, other care settings, and the community.

IV. Background and Significance of CCTM Model

- A. Rationale and need.
1. Growing demand for care coordination and transition management.
 - a. Health care spending in the United States is disproportionate; half of U.S. health care dollars are spent on 5% of the population (McDonald et al., 2011).
 - b. A small percentage of individuals with complex chronic conditions consume a high proportion of health care services and account for the bulk of health care spending; chronic conditions are expensive to treat and a major driver of increased health care spending (Thorpe, 2013).
 - c. Many struggle with multiple illnesses combined with social complexities such as, mental health and substance abuse, extreme medical frailty, and a host of social needs such as social isolation and homelessness (Craig, Eby, & Whittington, 2011).
 - d. Individuals with multiple needs are not able to navigate the complex and fragmented health care system (Swan, 2012).
 - e. Care providers recognize the need for better coordinated care that leverages community resources and aligns social determinants such as food, housing, and safe environments, but payment structures in the health care system do not allow such alignment (Kangovi et al., 2013).
 - f. Patients with chronic diseases and multiple co-morbidities are a vulnerable population. Health care for these at-risk patients can be fragmented, leading to nonbeneficial or redundant testing services. Uneven quality of care for at-risk populations can lead to poor patient outcomes and increased use of limited health care resources. At-risk patients are not well served by the traditional “rescue care” approach to health care delivery, such as frequent emergency room visits and hospitalizations, and would benefit from aggressive care coordination and navigation through the health care system to ensure smooth, seamless continuity of care.
 - g. The need for care coordination and transition management supports the Institute for Healthcare Improvement’s Triple Aim “improving the individual experience of care, improving the health of populations, and reducing the per capita cost of care for populations” (Berwick, Nolan, & Whittington, 2008, p. 760).

B. Background for CCTM Model.

1. March 1, 2010: Invitational conference on *Ambulatory Care Registered Nurse Performance Measurement* (Swan, Haas, & Chow, 2010).
 - a. Purpose: Formulate a research agenda and develop a strategy to study the testable components of the RN role related to care coordination and care transitions, improving patient outcomes, decreasing health care costs, and promoting sustainable system change.
 - b. Expert participants came from the fields of nursing, public health, managed care, research, practice, and policy.
 - c. Results: *Framework for RNs' contribution to care quality and in the context of national policies*.
 - (1) Recognize ambulatory as well as acute, subacute, and home care depends on an interprofessional team that significantly influences outcomes of care, and RNs are integral team members.
 - (2) Build on current assets in the areas of measure endorsement, public reporting, and performance-based payment programs, and seek opportunities to "join up" with other professional organizations.
 - (3) Describe and define ambulatory care RNs' contribution to "value-driven health care."
 - (4) Examine new opportunities within the Patient Protection and Affordable Care Act related to the medical home and improving patient outcomes, decreasing health care costs, and promoting sustainable system change.
 - (5) Explore a set of care coordination and care transition measures reflected in CMS rule-making (Swan et al., 2010).
2. March 23, 2010: Affordable Care Act.
3. Provisions of health care reform relate to care coordination and transition management (Swan & Haas, 2011).
4. April 2011: AACN Conference presentation on health care reform.
5. Constitutionality of ACA challenged.
6. September 2011: AHRQ grant submission – develop, implement, and evaluate a RN model for care coordination and transition management.
7. June 2012: Supreme Court upholds ACA.
8. *Health Affairs* article, November 2012 (Swan, 2012).
9. *Nursing Economic\$* article, January/February 2013 (Haas, Swan, & Haynes, 2013).
10. March 23, 2013: AHRQ grant resubmitted.

C. Significance of CCTM Model in relation to Affordable Care Act.

1. Majority of provisions are related to care coordination and care transitions, as well as health promotion and disease prevention (Naylor et al., 2011).
 - a. Interventions associated with these provisions are part of RNs' independent scope of practice (ANA, 2012a).
 - b. RNs have an essential role in the care coordination process (ANA, 2012a).
2. Defined the PCMH team with RNs as team members.
3. Focused on access to primary care versus enhanced use of specialists and acute care.
4. Fostered care coordination for complex chronically ill persons in ambulatory settings and across the care continuum.
5. Specified the need for individualized patient-centered care planning.
6. Extant models of care for chronically ill in the community are staffed by RNs working with complex chronically ill patients including Boulton's Guided Care Model (Boulton, Karm, & Groves, 2008) and Coleman's Care Transitions Model (Coleman, Parry, Chalmers, Chugh, & Mahoney, 2007).
7. Authorized the Accountable Care Organization program be administered by a new innovation center at CMS.
8. In 2011, launched the *Partnerships for Patients* program to achieve two goals.
 - a. Making care safer.
 - b. Improving care transitions.
9. In 2013, CMS finalized transitional care management codes. At this time these codes can be reported/billed by advanced practice nurses (APNs) but not RNs.
10. CMS is in the process of developing care coordination codes, the current rule-making on care coordination codes includes reporting/billing by APNs but not RNs; CMS does not plan to finalize these codes until 2015.
11. Beginning January 2015, one of the provisions of the ACA, the value modifier, will provide differential payment based on quality of care provided compared to cost during a defined performance period (CMS, 2013).

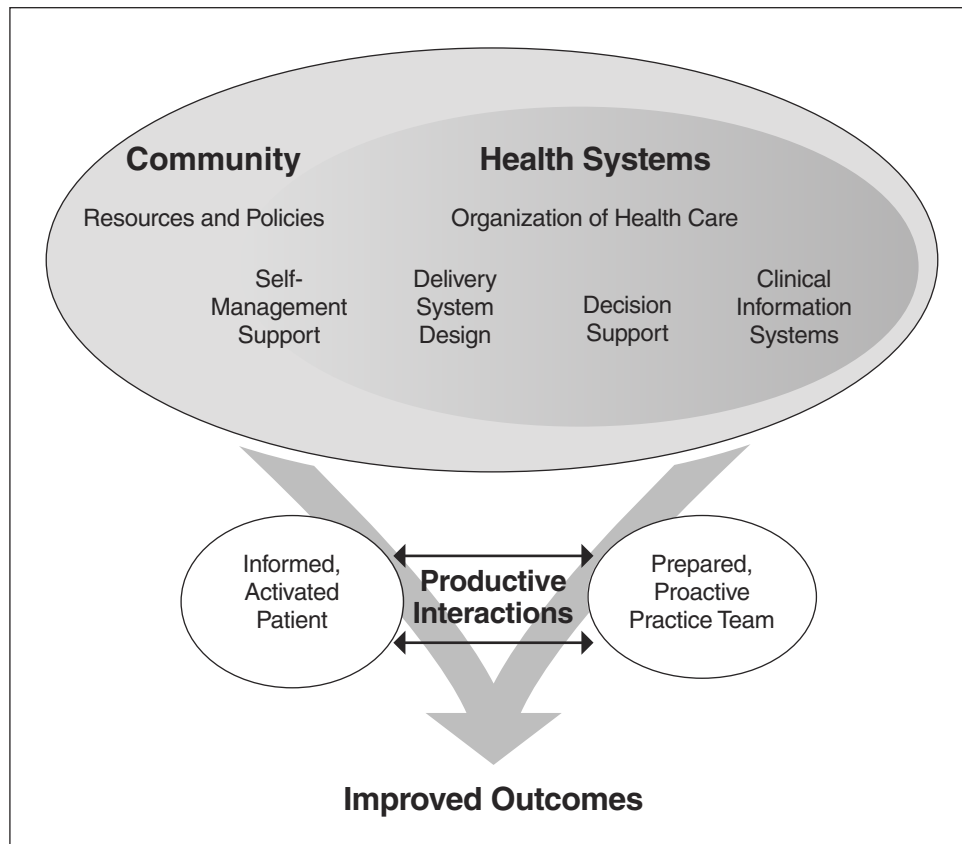
V. Selected Extant Care Coordination Initiatives

- A. Patient Aligned Care Teams (PACT) Model (True et al., 2012).
 1. In FY2010, the Veterans Health Administration (VHA) began implementation of the patient-centered medical home model, now known as PACT (Patient Aligned Care Team).
 2. Transform the VA health care delivery system to a more patient-centric model of care.

3. Primary care is the foundation of VHA health care.
 4. Transformation begins with primary care and permeates other areas of the health care delivery system to include specialty care, women's health care, geriatrics, and academic training programs.
 5. Long-term goals.
 - a. Provide superb access to primary care (including alternatives to face-to-face care) to meet veterans' needs and expectations.
 - b. Provide seamless coordination of care between VA providers and with non-VA providers.
 - c. Demonstrate a patient-centered culture through the redesign of primary care practices and team roles.
 6. Focus of PACT.
 - a. Partnerships with veterans.
 - b. Access to care using diverse methods.
 - c. Coordinated care among team members.
 - d. Team-based care with veterans at the center of their PACT.
 7. Patient Aligned Care Team.
 - a. Veterans work together with health care professionals to plan for whole-person care and lifelong health and wellness.
 - b. Care team considers all aspects of patient health, with an emphasis on prevention and health promotion.
 - c. Care is coordinated through collaboration.
 - d. Members of the team have clearly defined roles with a focus on forging trusted personal relationships; the result is coordination of all aspects of health care.
 - (1) PACT uses a team-based approach.
 - (2) The patient is the center of the care team that includes family members, caregivers, and health care professionals (a primary care provider, nurse care manager, clinical associate, and administrative clerk).
 - (3) When other services are needed to meet patient goals and needs, the PACT oversees and coordinates that care.
- B. Guided Care Model (Boult et al., 2008).
1. Guided care is driven by a highly skilled RN in a primary care office.
 2. The guided care nurse assists three to four physicians in providing high-quality chronic care for their patients in need of good chronic care.
 3. Those eligible for guided care are high-risk patients with several chronic conditions and complex health care needs in a primary care practice.
 4. Predictive modeling software to analyze patients' encounter data for the previous year. This "hierarchical condition category" software assigns points to each diagnosis from each encounter and computes a risk rating for each patient.
- VI. Methodology for CCTM Model for Ambulatory Care Nursing Adapted from Information Published in *Nursing Economic\$* (Haas et al., 2013)
-
- A. Developing the RN competencies for Care Coordination and Transition Management required:
1. Expertise of ambulatory care nurse leaders.
 2. Cost-effective, expeditious approach to bring leaders together.
 3. Opportunities to dialogue and build on each individual leader's knowledge, skills, and experience.
 4. Evidentiary review completed by Expert Panel 1.
 - a. Members represented practice and education, along with public, private, military, and veterans' organizations.
 - b. 15 states in east, west, north, south, and central U.S. and the District of Columbia.
 - c. Following a search in MEDLINE, CINAHL Plus, and PsycINFO, 82 journal articles plus white papers available online from major organizations were selected for review. Expert Panel 1 worked in dyads and reviewed four to five articles, then abstracted data to a table of evidence (TOE) concluding their work in February 2012. A second literature search was completed in the summer of 2013. An additional 58 articles were reviewed and abstracted following the same methodology by members of the Expert Panel, then added to the existing TOE.
 - d. The 26-member panel worked in dyads and abstracted data to a table of TOE including:
 - (1) Authors of study column.
 - (2) Study title column.
 - (3) Research questions column.
 - (4) Research design type column.
 - (5) Setting and sample, inclusion/exclusion criteria column.
 - (6) Methods, intervention, and/or instruments.
 - (7) Analyses column.
 - (8) Key findings column.
 - (9) Recommendations column.
 - (10) Column listing dimension or dimensions identified with activity or activities that are supporting and/or contributing to care coordination and transition management.
 5. Use of data summary techniques to capture and share outcomes achieved by each Expert Panel.
 6. Focus group methods.
 - a. Defined as a method of bringing together people from similar backgrounds or experiences to discuss a specific topic, guided by a facilitator who elicits responses from the group, but does not influence responses.

- b. For this project, focus group method and on-line time were used to:
 - (1) Clarify methods and outcome expectations.
 - (2) Discuss issues with evidence evaluation such as ambiguities and contradictions in evidence.
 - (3) Absence of sufficient description in evidence materials.
 - (4) Sharing of concerns.
 - (5) Sharing of insights and expertise.
- B. Identifying dimensions of care coordination and transition management.
 - 1. Defining dimensions.
 - a. In the literature, often activities are listed that are part of care coordination such as developing a plan of care or monitoring progression of established goals.
 - b. These activities fit together within a broader construct or dimension such as planning.
 - c. When developing a role that reflects all of the major dimensions or constructs that make up the role, use of dimensions allows for addition or subtraction of relevant activities under each dimension as the role evolves.
 - 2. Dimensions identified and defined by Expert Panel 2.
 - a. This 16-member panel was charged with:
 - (1) Defining the dimensions, identifying core competencies.
 - (2) Describing the activities linked with each competency for care coordination and transition management in ambulatory and settings across the continuum.
 - (3) Using focus group methods online, the expert panel identified nine patient centered-care dimensions and associated activities of care coordination and transition management.
 - b. Nine evidence-based dimensions.
 - (1) Support for self-management.
 - (2) Education and engagement of patient and family.
 - (3) Cross setting communication and transition.
 - (4) Coaching and counseling of patients and families.
 - (5) Nursing process including assessment, plan, implementation/intervention, and evaluation; a proxy for monitoring and intervening.
 - (6) Teamwork and collaboration.
 - (7) Patient-centered care planning.
 - (8) Decision support and information systems.
 - (9) Advocacy.
 - c. The evidence-based dimensions and activities were validated using informal focus groups at the AACN National Conference in May 2012.
- 3. Preliminary Competencies identified by Expert Panel 2 using the QSEN framework (Cronenwett et al., 2007).
 - a. Knowledge.
 - b. Skills.
 - c. Attitudes.
- 4. Work was also guided by Wagner's Chronic Care Model (Wagner, 1998) (see Figure 1).
- C. Developing Competencies for Care Coordination and Transition Management.
 - 1. Once dimensions were discovered in the translational research project, the named dimension became the competency. Since the *CCTM Core Curriculum* is a first edition and the implementation of the RN in CCTM is a new role, the definition of each competency on the first page of each chapter offers several definitions of the competency taken from the evidence discovered in the literature. Users (organizations) are free to use the definitions offered to create a more abbreviated definition that is consonant with their setting and population served.
 - 2. Specify education and evaluation needed for successful practice within each dimension of the role.
 - 3. In 2003, the IOM's Health Professions Education Report recommended educators provide learning experiences so that graduates were prepared to provide patient-centered care as collaborating members of an interdisciplinary team using evidence-based practice, quality improvement methods, and informatics. This was a stimulus for development of the QSEN initiative (Cronenwett et al., 2007). The six QSEN competencies and their Knowledge, Skills, and Attitudes tables of expected behaviors have been embraced by nursing undergraduate and graduate educators. Of note is the QSEN specification of attitudes instead of abilities and judgment that were specified in the preliminary position statement (ANA, 2008). Attitudes are extremely relevant in specification of quality and safety competencies and behavior or performance expectations. It is often health care provider attitudes that override the knowledge and skills expectations of performance. A good example of this is hand hygiene. Providers have extensive knowledge of rationale for hand washing and skills to do it, but often do not practice hand hygiene, letting attitudes about emergent needs take precedence. That is why hand hygiene compliance is about 60% in health care.
 - 4. The QSEN format (Cronenwett et al., 2007) was used to identify expected Knowledge, Skills, and Attitudes (KSA) behavior for each CCTM competency or dimension.

Figure 1.
The Chronic Care Model



Developed by The MacColl Institute.
© ACP-ASIM Journals and Books. Reprinted with permission.

- D. Verifying dimensions and competencies.
1. In August 2012, using focus group methods online, Expert Panel 3 reviewed, confirmed, and created a table of dimensions, activities, and competencies including knowledge, skills, attitudes for ambulatory care RN care coordination, and transition management.
 2. After much discussion, Expert Panel 3 determined the original 8th dimension of decision support and information systems, as well as telehealth practice, were technologies that support all dimensions.
 3. Population health management became the new 8th dimension given the prominence it is assuming in outpatient care even though there was little discussion of it in the literature reviewed.
 4. Expert Panel 3 also determined methods to be used to enhance teamwork and interprofessional collaboration in outpatient settings.
 5. Nationally recognized core competencies for interprofessional collaborative practice QSEN competencies, and public health nursing competencies, overlap with the dimensions and competencies

needed for RN care coordination and transition management (see Table 1).

- E. Expert Panel 4 was convened in summer 2013. This panel was charged with writing the 13 chapters of the *CCTM Core Curriculum*. Names of panelists are in the contributor list in the beginning of this text.

VII. Logic Model

As we prepared to work with the expert panelists who were writing chapters for the *CCTM Core Curriculum*, we developed a Logic Model to guide the organization of the chapters to identify not only activities but also processes and outcomes involved in each of the dimensions. We knew from analyzing other care coordination and transition models that the main outcomes identified were emergency room visits and hospital re-admission rates. When other quality of life outcomes were reported, there was a great variety of outcomes specified, but often there was no distinction as to whether they were short, medium, or long-term outcomes. We decided to try to plot the CCTM Model within a Logic Model as illustrated in the Appendices.

Table 1.
Crosswalk of Dimensions for Care Coordination and Transition Management with Core Competencies
(Haas, Swan, & Haynes, 2013)

Dimension RN in Care Coordination and Transition Management	Quality and Safety Education for Nurses (QSEN) Core Competencies	Interprofessional Education Collaborative Core Competencies	Public Health Nursing Competencies
Support Self-Management	Patient-Centered Care		
Education and Engagement of Patient and Family	Patient-Centered Care		
Cross Setting Communication and Transition	Patient-Centered Care	Interprofessional Communication	Domain #3: Communication Skills
Coaching and Counseling of Patients and Families	Patient-Centered Care		Domain #4: Cultural Competency Skills
Nursing Process: Assessment, Plan, Intervention, Evaluation	Evidence-Based Practice Quality Improvement	Roles and Responsibilities	Domain #1: Analytic Assessment Skills
Teamwork and Collaboration	Teamwork and Collaboration	Teams and Teamwork	Domain #8: Leadership and System Thinking Skills
Patient-Centered Planning	Patient-Centered Care	Values/Ethics for Interprofessional Practice	Domain #1: Analytic Assessment Skills
Population Health Management	Quality Improvement Informatics		Domain #5: Community Dimensions of Practice Skills Domain #6: Basic Public Health Sciences Skills
Advocacy	Patient-Centered Care Care Safety		Domain #2: Policy Development/Program Planning Skills

VIII. Mechanics

- A. The content in the *CCTM Core Curriculum* is presented in outline format for easy review and reference. Key terms that are defined in the text are captured in the Glossary. Resources and published references are identified throughout the text and at the end of chapters for further information. It is important to realize that this content captured the best evidence and information available at a point in time, and the reader is encouraged to seek current sources of information as new research and evidence on care coordination and transition management are being published.
- B. Organization of each chapter.
 1. Definition of the dimension for the chapter using evidence from literature reviewed and enhanced where necessary by expert opinion.
 2. Purpose of chapter: Broad outcome statement or goal that summarizes the specific topic and aim of the chapter.
 3. Learning objectives: Brief, clear statements that describe what the reader is expected to achieve as a result of reading the chapter.
 4. Brief introduction to the competency.
 5. Content outline for the competency.
 6. Competencies: Sets of knowledge, skills, and attitudes that enable a nurse to perform in a specific role such as the registered nurse in care coordination and transition management.
 7. Finalized list of knowledge, skills, and attitudes for each competency modeled after the QSEN (Cronenwett et al., 2007) entry/pre-licensure competencies.
 8. Nationally recognized core competencies for interprofessional collaborative practice (American Association of Colleges of Nursing, 2011), QSEN competencies (Cronenwett et al., 2007), and public health nursing competencies (Quad Council of the Public Health Nursing Organizations, 2011), overlap with the dimensions and competencies needed for RN care coordination and transition management.
 9. Suggested process and outcome indicators for competencies where available.
 10. References.

IX. Contents

- A. The majority of the book is composed of nine chapters listed below, one for each evidence-based dimension, written by nurse experts. This compilation is the work of a large number of ambulatory care and acute care nurse leaders representing practice, education, and research. The authors would like to acknowledge the collaboration with the leadership from the Academy of Medical-Surgical Nurses (AMSN) on the four Expert Panels.
1. Advocacy.
 2. Education and Engagement of Patients and Families.
 3. Coaching and Counseling of Patients and Families.
 4. Patient-Centered Care Planning.
 5. Support for Self-Management.
 6. Nursing Process (Proxy for Monitoring and Evaluation).
 7. Teamwork and Collaboration.
 8. Cross Setting Communications and Care Transitions.
 9. Population Health Management.
- B. One chapter is dedicated to the transition from acute care to ambulatory care and the critical nature of hand-offs in ensuring patient safety and quality of care.
- C. Two chapters are devoted to technologies that provide decision support and information systems for all dimensions of care coordination and transition management.
1. Informatics Nursing Practice.
 2. Telehealth Nursing Practice.

X. Who Will Benefit From This Book?

This text is written for you, the registered nurse – whether you are a nurse working in ambulatory care, in a hospital, an extended care facility, a patient’s home, a community setting; a student nurse; a nurse educator; or a nurse who functions in any of the other diverse places where nurses are coordinating care and managing transitions. Whatever your role, you will find this groundbreaking new reference an indispensable guide to the state of research evidence for care coordination and transition management.

XI. How Can I Use This Book?

This core resource on care coordination and transition management is ideal for:

- A. Orienting nurses transitioning into ambulatory care settings as well as acute, subacute, and home care across the continuum about care coordination and transition management.
- B. Orienting existing nursing staff in acute care settings and ambulatory care settings about care coordination and transition management.
- C. Orienting nurses’ transition into the RN care coordination and transition management role.

- D. Developing competencies, standards, policies, and procedures.
- E. Revising performance appraisal instruments for ambulatory care nurses and nurses in other settings doing CCTM.
- F. Enhancing educational materials/programs for nurses in CCTM.
- G. Identifying nurses’ structure and process contributions to patient outcomes.
- H. Enhancing high-risk patient outcomes in a pay-for-performance environment.
- I. Delineating the value proposition of the RN in the context of interprofessional team-based care.
- J. Expanding/enhancing the use of longitudinal care planning for patients across providers of care and settings of care.
- K. Developing, implementing, and evaluating quality improvement projects in your organizations around the dimensions.
- L. Developing and implementing evidence-based projects and research projects guided by the dimensions.
- M. Planning and implementing action plans to meet the new Magnet® standards related to ambulatory care.

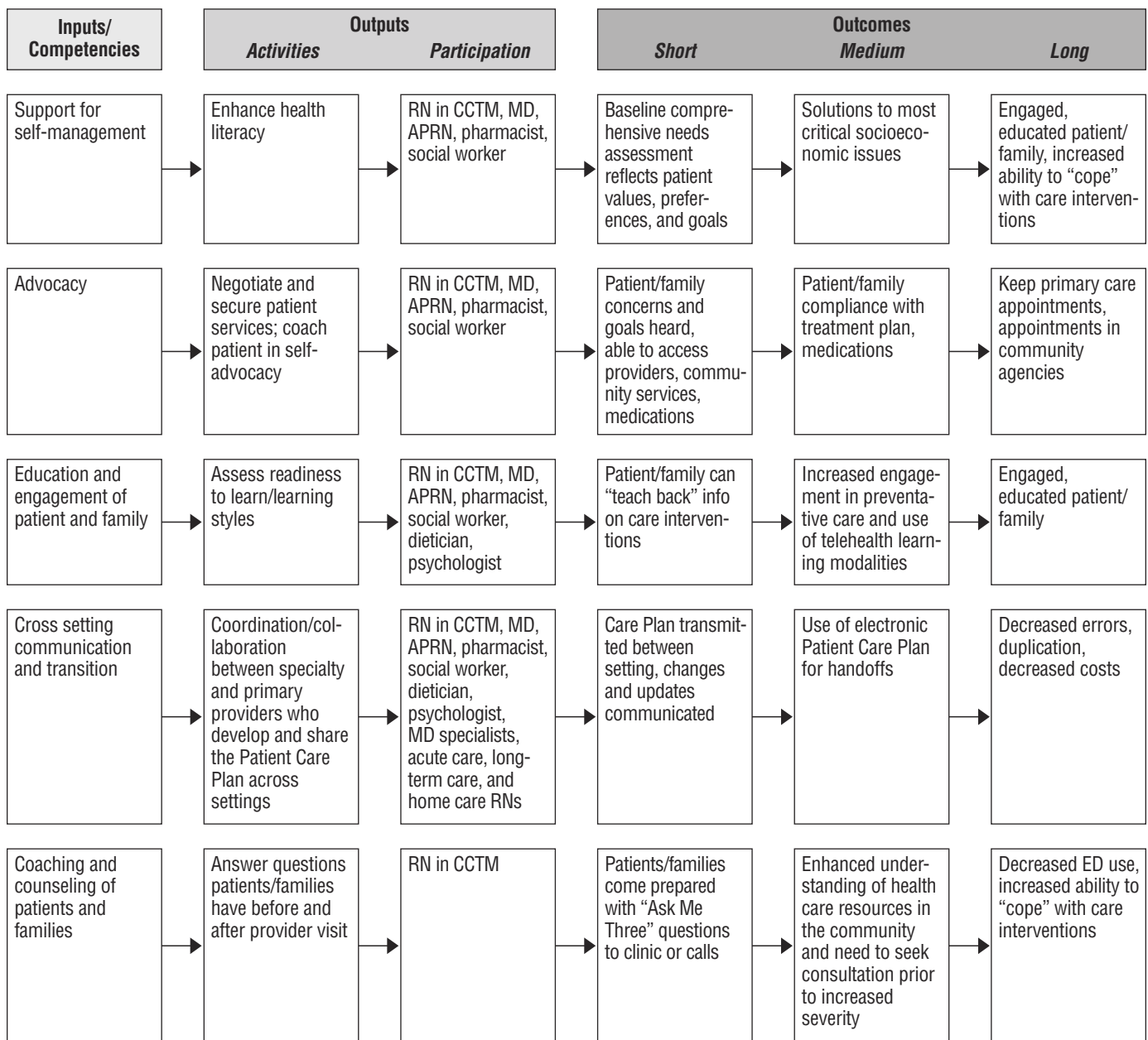
References

- American Academy of Nursing (AAN). (2012). *The imperative of patient, family, and population centered interprofessional approaches to care coordination and transitional care: Policy brief*. Washington, DC: Author.
- American Association of Colleges of Nursing. (2011). Health educators and foundations release competencies and action strategies for interprofessional education. *Journal of Professional Nursing*, 27(4), 195-196.
- American Nurses Association (ANA). (2008). *Position statement on competence and competency*. Silver Spring, MD: Author.
- American Nurses Association (ANA). (2012a). *Care coordination and registered nurses’ essential role: Position statement*. Silver Spring, MD: Author.
- American Nurses Association (ANA). (2012b). *The value of nursing care coordination: White paper*. Silver Spring, MD: Author.
- American Nurses Association (ANA). (2013). *Framework for measuring nurses’ contributions to care coordination*. Silver Spring, MD: Author.
- Berwick, D., Nolan, T., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, 27(3), 759-769.
- Boult, C., Karm, L., & Groves, C. (2008). Improving chronic care: The “Guided Care” model. *The Permanente Journal*, 12(1), 50-54.
- Centers for Medicare & Medicaid Services (CMS). (2013). *Summary of 2015 physicians’ value-based payment modifier policies*. Baltimore, MD: Author. Retrieved from <http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf>
- Cipriano, P., Bowles, K., Dailey, M., Dykes, P., Lamb, G., & Naylor, M. (2013). The importance of health information technology in care coordination and transitional care. *Nursing Outlook*, 61, 475-489.
- Coleman, E., & Boult, C. (2003). Improving the quality of transitional care for persons with complex care needs. *Journal of the American Geriatrics Society*, 51(4), 556-557.
- Coleman, E.A., Parry, C., Chalmers, S.A., Chugh, A., & Mahoney, E. (2007). The central role of performance measurement in improving the quality of transitional care. *Home Health Care Services Quarterly*, 26(4), 93-104.

continued on page 12

**Appendix 1.
Program: CCTM Depicted within a Logic Model**

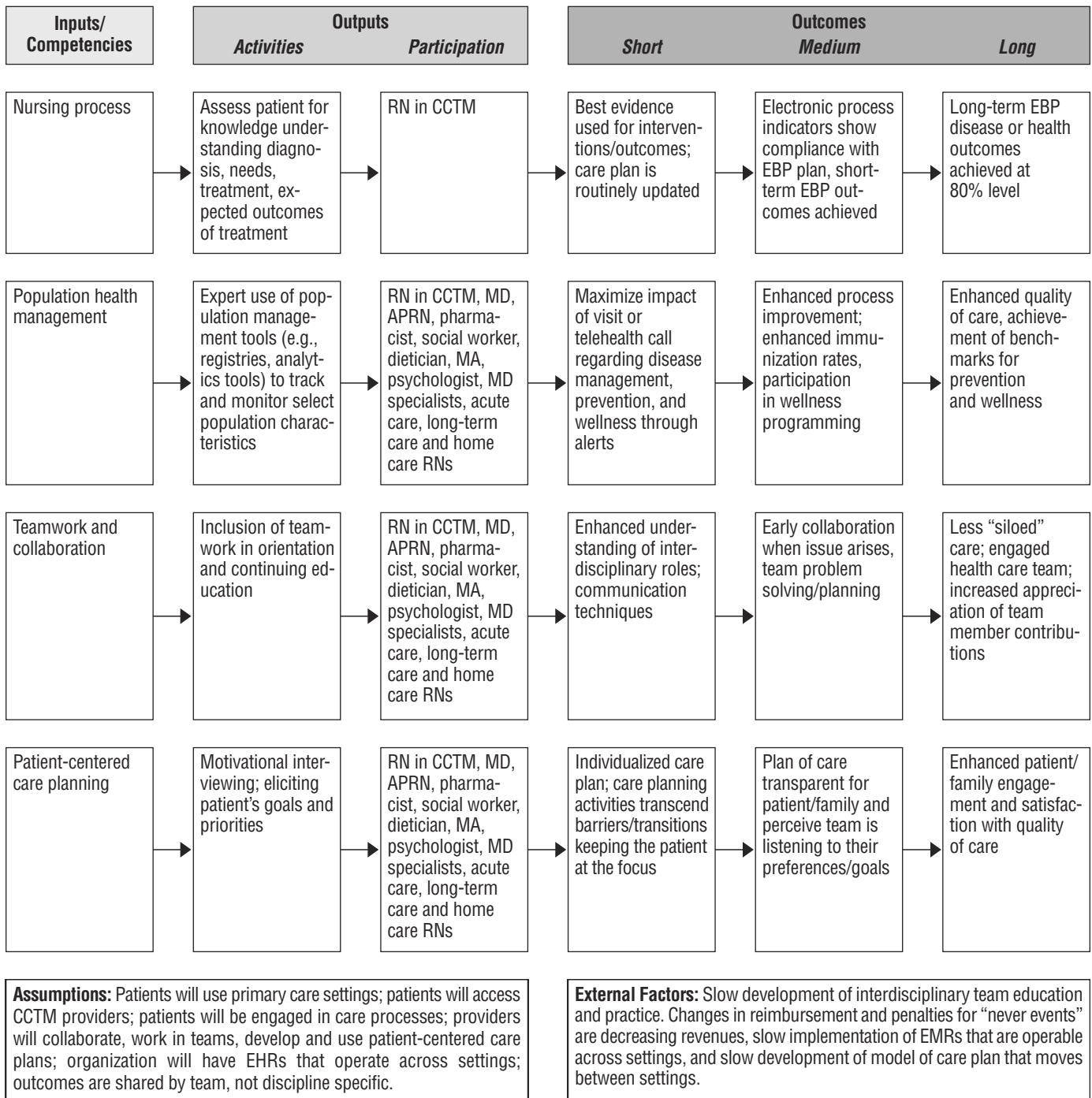
Situation: The Care Coordination and Transition Management (CCTM) Model evolved to standardize work of ambulatory care nurses using evidence from interdisciplinary literature on care coordination and transition management. The vision is the CCTM Model would specify dimensions of CCTM and competencies needed to perform CCTM and make possible development of knowledge, skills, and attitudes needed for each competency so the registered nurse (RN) will meet needs of patients with complex chronic illnesses (and their families) being cared for in Patient-Centered Medical Homes (PCMH), as well as traditional and nontraditional outpatient settings, and acute, subacute, and home care settings, and their preparation so work as an RN in CCTM would be recognized and reimbursed by the Centers for Medicare & Medicaid Services.



© S. Haas & B.A. Swan

continued on next page

Appendix 1. (continued)
Program: CCTM Depicted within a Logic Model



© S. Haas & B.A. Swan

References

continued from page 9

- Craig, C., Eby, D., & Whittington, J. (2011). *Care coordination model: Better care at lower costs for people with multiple health and social needs*. Cambridge, MA: Institute for Healthcare Improvement. Retrieved from <http://www.ihc.org/knowledge/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx>
- Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., ... Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook*, 55(3), 122-131.
- Haas, S., & Swan, B.A. (2014). Care coordination models for achieving quality and safety outcomes for patients and families. In G. Lamb (Ed.), *Care coordination: The game changer – How nursing is revolutionizing quality care*. Silver Spring, MD: American Nurses Association.
- Haas, S., Swan, B.A., & Haynes, T. (2013). Developing ambulatory care registered nurse competencies for care coordination and transition management. *Nursing Economic\$*, 31(1), 44-49, 43.
- Institute of Medicine (IOM). (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academies Press.
- Institute of Medicine. (IOM). (2010). *The future of nursing: Leading change, advancing health* (1st ed.). Washington, DC: National Academies Press.
- Kangovi, S., Barg, F., Carter, T., Long, J., Shannon, R., & Grande, D. (2013). Understanding why patients of low socioeconomic status prefer hospitals over ambulatory care. *Health Affairs*, 32(7), 1196-1203.
- Lamb, G. (Ed.) (2014). *Care coordination: The game changer – How nursing is revolutionizing quality care*. Silver Spring, MD: American Nurses Association.
- McDonald, K.M., Schultz, E.S., Albin, L., Pineda, N., Lonhart, J., Sundaram, V., ... Malcolm, E. (2011). *Care coordination measures atlas* (AHRQ Publication No.11-0023-EF). Rockville, MD: Agency for Healthcare Research and Quality.
- McDonald, K., Sundaram, V., Bravata, D., Lewis, R., Lin, N., Kraft, S.A. ... Owens, D.K. (2007). Care coordination. In K. Shojania, K. McDonald, R. Wachter, & D. Owens (Eds.), *Closing the quality gap: A critical analysis of quality improvement strategies* (AHRQ Publication No. 04(07)-0051-7). Technical Review 9 (Prepared by Stanford-UCSF Evidence-Based Practice Center under contract No. 290-02-0017). Vol. 7. Rockville, MD: Agency for Healthcare Research and Quality.
- National Quality Forum. (2010). *Preferred practices and performance measures for measuring and reporting care coordination: A consensus report*. Washington, DC: Author.
- Naylor, M., Aiken, L., Kurtzman, E., Olds, D., & Hirschman, K. (2011). The CARE SPAN: The importance of transitional care in achieving health reform. *Health Affairs*, 30(4), 746-754.
- Naylor, M., & Sochalski, J. (2010). Scaling up: Bringing the transitional care model into the mainstream. *Commonwealth Fund Issue Brief*, 1453(103), 1-11.
- Patient Protection and Affordable Care Act. (2010). Public Law 111-1148, §2702, 124 Stat. 119, 318-319.
- Quad Council of Public Health Nursing Organizations. (2011). *Quad Council competencies for public health nurses*. Retrieved from <http://www.achne.org/files/Quad%20Council/QuadCouncilCompetenciesforPublicHealthNurses.pdf>
- Swan, B.A. (2012). A nurse learns firsthand that you may fend for yourself after a hospital stay. *Health Affairs*, 31(11), 2579-2582.
- Swan, B.A., & Haas, S. (2011). Health care reform: Current updates and future initiatives for ambulatory care nursing. *Nursing Economic\$*, 29(6), 331-334.
- Swan, B.A., Haas, S., & Chow, M. (2010). Ambulatory care registered nurse performance measurement. *Nursing Economic\$*, 28(5), 337-339, 342.
- Thorpe, K. (2013). Treated disease prevalence and spending per treated case drove most of the growth in health care spending in 1987-2009. *Health Affairs*, 32(5), 851-858.
- True, G., Butler, A., Lamparska, B., Lempa, M., Shea, J., Asch, D., & Werner, R. (2012). Open access in the patient-centered medical home: Lessons learned from the Veterans Health Administration. *Journal of General Internal Medicine*, 28(4), 539-545.
- Wagner, E.H. (1998). Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*, 1(1), 2-4.

Additional Reading

- Naylor, M. (2000). A decade of transitional care research with vulnerable elders. *Journal of Cardiovascular Nursing*, 14(3), 1-14.