Care Coordination and Transition Management (CCTM)

Press Kit  

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What is Care Coordination and Transition Management (CCTM)?

Care coordination and transition management (CCTM) is a way for the health care team to involve patients and their families in organizing the patient’s care activities among several health care team members, health care services, and settings of care. It helps patients navigate the maze of specialists, hospital departments, outpatient appointments, tests, procedures, medications, and follow-up appointments.

What does a CCTM nurse do?

A CCTM nurse helps to keep everyone on the health care team in the loop about a patient’s condition, tests, diagnosis, and treatment. A CCTM nurse also guides patients and their families between settings, levels, and providers of care. By serving as the point of contact for a patient, CCTM nurses help treatments stay on track. This leads to fewer appointments, fewer repeated or unnecessary tests, and fewer trips back to the hospital. All of this helps patients to save money and avoid time away from work and family. In the long run, CCTM nurses are a big step toward lower national health care costs and improved health.

Who benefits from having a CCTM nurse in their corner?

- People who have a chronic illness or disease such as diabetes, obesity, asthma, or high blood-pressure who require treatments and long-term follow-up care.
- People who have a sudden, unexpected diagnosis – like cancer – or a serious accident.
- Older adults with complicated health care needs.
- Caregivers who are responsible for a spouse or family member.

FAST FACTS

- 1 in 2 Americans has more than one chronic (long-term) condition.¹
- 5% of Americans are responsible for 50% of U.S. spending on health care.²
- In 2014, the U.S. spent $3 trillion on health care, with costs continuing to rise.³
Care Coordination and Transition Management (CCTM)

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Why does CCTM matter?

**BETTER CARE**

- A partner in your treatment plan.
- One contact for all your care needs.
- Guidance as you move through the health care system.
- A health care professional in your corner who makes sure your voice is heard.

**LOWER COSTS**

CCTM helps treatments stay on track, leading to fewer appointments, fewer hospital trips, and fewer medications.

- Staying healthy saves money and means less time away from family and work.
- If everyone had a CCTM nurse, it would be a big step toward lower national health care costs.
How does CCTM work?

Sally has diabetes, a long-term (chronic) condition.

- Her CCTM nurse made sure she found a foot specialist after her last annual check-up.
- Sally's nurse worked together with her health team to find a less expensive prescription when she couldn't afford her insulin.
- The nurse helped Sally's husband understand her new diet so they could change what they ate at home and when they went out.
- CCTM helps keep Sally's long-term condition under control so that she can stay healthy and happy.

Peter had cancer and needed treatment in the hospital and when he came back home.

- Peter's CCTM nurse helped him get better pain control while he was in the hospital.
- His nurse helped change a medication after he had side effects so Peter could stay out of the hospital.
- After Peter's surgery, his nurse helped him move from the hospital to rehab so he could focus on getting well with no bumps in the road.
- CCTM helped Peter feel less afraid and more confident during a scary time in his life.

The Johnson family has two small children at home.

- A CCTM nurse gave advice to their family when their premature daughter was born.
- Their nurse helped them care for Mr. Johnson's mother when she became terminally ill and moved in with them.
- CCTM helps the Johnson family keep their healthcare costs low by guiding them through the health care system when they need it most.
Who's Who: Experts in Care Coordination and Transition Management

Lead Editor Sheila A. Haas, PhD, RN, FAAN
is a Professor and former Dean of the Marcella Niehoff School of Nursing at Loyola University Chicago. Dr. Haas is a Fellow in the American Academy of Nursing. She developed the Nursing Administration major and the dual degree MSN/MBA at Loyola University as well as the undergraduate non-nursing Health Care Administration major. She also holds a joint appointment to the Loyola University Chicago Graduate School of Business. She currently teaches in the graduate program in nursing (MSN, DNP and PhD), as well as, the MBA program. She does research, publication and consulting in the areas of translational research and evidence-based practice, care coordination and transition management, clinical ladders, work redesign and evaluation, differentiated practice, and nursing intensity systems.

Editor Beth Ann Swan, PhD, CRNP, FAAN
is Dean at the Jefferson School of Nursing and Senior Fellow in the Jefferson School of Population Health at Thomas Jefferson University. Past president of the American Academy of Ambulatory Care Nursing and a 2007-2010 Robert Wood Johnson Executive Nurse Fellow. Currently she serves on the Care Coordination Steering Committee for the Care Coordination Measure Endorsement. Dr. Swan is Co-Editor of the text, Care Coordination and Transition Management Core Curriculum. She has published and presented nationally and internationally on topics related to ambulatory care, care coordination and transition management, and technology applications for education and practice.

Editor Traci S. Haynes, MSN, BA, RN, CEN
has been a member of AAACN since 1996 and has served on many committees and work groups, including nominating committee and program planning. She is a member of the TNP SIG, has taught many TNPCCs across the country and at the annual conference, and has helped to edit/update the Telehealth Nursing Practice Essentials textbook. She co-authored a chapter in the 2nd edition of the core curriculum and has served on the AAACN Board of Directors as a director, treasurer, and president. Traci most recently served as the project manager and co-editor of the Care Coordination and Transition Management (CCTM) Core Curriculum, as well as co-author of two of its chapters and the presenter/co-presenter of two of the online modules.

Susan M. Paschke, MSN, RN-BC, NEA-BC
is Chief Clinical and Quality Officer at the Visiting Nurse Association of Ohio in Cleveland. Previously she was the Associate Chief Nursing Officer for Operations at Cleveland Clinic in addition to roles as staff nurse, clinical manager, assistant director and administrator during her 25 year career at the organization. Her expertise is in clinical management, nursing leadership and quality improvement. Susan is a member of numerous professional organizations including the American Nurses Association, the American Organization of Nurse Executives, the American College of Healthcare Executives, the National Association of Healthcare Quality, Sigma Theta Tau and the Ohio Association of Advanced Practice Nurses. Susan is certified in ambulatory care and as an advanced nurse executive through ANCC and has been an instructor for the Ambulatory Care Nursing Certification review course for the past 10 years.
Press Quotes and Releases

“If the goal of care coordination and transition management is to prevent patients from falling through the cracks, it is critical that there are national, formal standards in place.”
- Nancy May, MSN, RN-BC, NEA-BC, President of the American Academy of Ambulatory Care Nursing (AAACN)

12/9/2015: AAACN Sets Scope and Standards for Care Coordination and Transition Management [PDF]

“Registered nurses are the largest group of frontline health care professionals. That’s why it is crucial for nurse leaders to take initiative and prepare their delivery systems and nursing staff for CCTM.”
- Pamela Thompson, MS, RN, CENP, FAAN, American Organization of Nurse Executives (AONE) CEO and American Hospital Association Senior Vice President for Nursing

9/3/2015: “Nursing Organizations Enlist Nurse Leaders In National Effort for Care Coordination” [PDF]

“Care coordinators are key to ensuring that top quality services are provided. They help patients navigate the health care system, which improves outcomes and helps to lower costs.”
- Marianne Sherman, MS, RN-BC, President of the American Academy of Ambulatory Care Nursing (AAACN)

7/1/2014: “Ambulatory Care and Medical-Surgical Nursing Organizations Collaborate on First-Ever Certification Exam for Care Coordination and Transition Management”
Nurse Education: About the CCTM Core Curriculum Text and Online Course

13 chapters written by nurse experts

- This publication provides the essential core knowledge and competencies for nurses who coordinate care and manage transitions of patients among settings, levels of care, and providers.
- Written for RNs in a variety of settings and roles, including student nurses, nurse educators, or nurses in any number of diverse places where they are coordinating care and managing transitions.
- CCTM settings might include (but are not limited to) ambulatory (outpatient) care, in a hospital, an extended care facility, a patient’s home, or a community setting.

Topics include: Advocacy • Education and Engagement of Patients and Families • Coaching and Counseling of Patients and Families • Teamwork and Collaboration • Cross Setting Communications and Care Transitions • CCTM Between Acute Care and Ambulatory Care • Telehealth Nursing Practice.

The CCTM Online Course corresponds with the Core Curriculum.

- CCTM 1: View recordings and power point slides presented by CCTM content experts. Available through Digitell. Earn 26.4 contact hours.
- CCTM 2: Interactive activities are presented as you view & listen to the content. Available through HealthStream. Earn 23.25 contact hours.
- Both versions prepare nurses for the Certified in Care Coordination and Transition Management (CCCTM) exam and contain PDFs of the corresponding CCTM Core Curriculum chapters.
Setting the Standard: About the CCTM Scope and Standards of Practice Publication

The Scope and Standards of Practice for Registered Nurses in Care Coordination and Transition Management is the first publication to establish national, formal standards of practice for nurses in this role.

Written for acute and ambulatory care nurses by a task force of nurses and nurse leaders, the scope and standards addresses both the clinical and management dimensions of care coordination and transition management (CCTM). It also includes a framework for developing the interprofessional health care team and guides institutions and professional staff on policies, procedures, role descriptions and competencies.

Raising the Bar: About the Certified in Care Coordination and Transition Management (CCCTM) Credential

The CCCTM credential is the first validation of RN care coordination and transition management.

This certification validates the unique knowledge, skills, and abilities of the registered nurse in care coordination in ambulatory, acute, community, and other care settings. It is the recognized path for registered nurses to build and demonstrate commitment, confidence, and credibility. To be eligible to test for certification, registered nurses must hold a current license in the United States or territories, have practiced 2 years as a registered nurse in a Care Coordination and Transition Management role, and accrued 2,000 hours of Care Coordination and/or Transition Management practice within the last 3 years as a registered nurse.
References


Additional resources for information about chronic conditions and costs of care


Chronic Disease Overview from the Centers for Disease Control and Prevention - [http://www.cdc.gov/chronicdisease/overview/](http://www.cdc.gov/chronicdisease/overview/)