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Introduction

The American Academy of Ambulatory Care Nursing (AAACN), the specialty nursing organization for those practicing in ambulatory care settings, is responsible for establishing and maintaining the standards for ambulatory care nursing practice. To fulfill this responsibility, AAACN has published standards for professional ambulatory care nursing since 1987.

The current standards include:

- 2010 – AAACN published the *Scope and Standards of Practice for Professional Ambulatory Care Nursing,* which addresses the delivery of ambulatory clinical care and administrative nursing in general.
- 2011 – AAACN published the *Scope and Standards of Practice for Professional Telehealth Nursing,* which specifically addresses professional nursing practice in the subspecialty of telehealth.

AAACN embarked on a multi-year journey developing the role of the ambulatory care registered nurse (RN) in care coordination and transition management (CCTM). The RN-CCTM Model was developed, including its dimensions, competencies, core curriculum, and online course. Additionally, AAACN included input from the Academy of Medical-Surgical Nurses (AMSN) to ensure that acute care was incorporated in this body of work that spans the continuum of care (AMSN, 2009, 2012).

This document, *Scope and Standards of Practice for Registered Nurses in Care Coordination and Transition Management* is an evolution of AAACN's body of work and a major step forward for nurses in CCTM roles. It is the first statement of the scope and standards of practice for RNs engaged in CCTM. These roles are part of the vision of the "transformed future of health care" developed by the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine (IOM). Today's health care institutions have responded to the requirements of the Affordable Care Act (ACA) of 2010 and are in the process of changing the way health care is delivered. The ACA offers nursing multiple opportunities to facilitate health systems' improvements and the mechanics of health care delivery (IOM, 2011). CCTM roles focus on communicating and partnering with other professional health care colleagues across diverse health care settings. These settings include ambulatory care, acute care, post-acute care, long-term care facilities, and diverse community settings.

The actions and competencies within current CCTM roles have been evolving in America over the past 200 years and more intensely over the past 25 years. Yet, there has never been formal identification, specification, and/or publication of the scope and standards of practice. Doing so is a priority if nursing is to respond to the vision and challenges presented by the IOM report (2011), which includes identifying and defining nurses' contributions to health care quality, access, and value.

This publication may be used to:

1. Provide guidance for health care institutions and professional staff in regards to the organizational structure and processes (e.g., institutional policies, procedures, role descriptions and competencies) needed to facilitate RN practice in the competent provision of CCTM.
2. Guide the provision of quality nursing care during CCTM processes and activities.
3. Facilitate the development and expansion of the RN practice related to CCTM.
4. Facilitate the evaluation of the RN performance in CCTM activities (e.g., performance appraisals and peer review).
5. Stimulate participation in CCTM research and evidence-based practice.
6. Guide clinical, organizational, and health system performance improvement initiatives that optimize patient and/or population outcomes through CCTM (National Committee for Quality Assurance, 2013).
7. Guide ethical practice and patient advocacy in CCTM processes and activities.

This document is the inaugural statement of the scope and standards of practice for CCTM developed and published by AAACN. It includes:

- The historical evolution of modern day CCTM.
- The definitions of CCTM.
- The defining characteristics for the RN practicing in the CCTM role.
- An initial conceptual framework that was adapted from models cited in the care coordination and transition management core curriculum text (Haas, Swan, & Haynes, 2014). The framework offers a structure for cataloging and unifying the distinct relationships and interactions among the RN, the patient, group and/or population, the interprofessional health care team, and the resources across the health care continuum.
- Sixteen standards for the RN practicing CCTM that address both the clinical dimension and the management dimension.

This document may be used as a tool to advance professional CCTM nursing practice, patient and population health (Halpern & Boulter, 2000), and the performance outcomes of health care institutions.

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Scope of Practice for Registered Nurses in Care Coordination and Transition Management (CCTM)

I. Historical Evolution of CCTM

CCTM evolved from multiple health care models that emerged in the United States dating back to the 1800s. Today's RN-CCTM Model is rooted in care management and innovative hospital and pediatric physician practices that occurred during the latter part of the 1900s. A major influence for today's model includes changes in the funding system of health care: from reimbursement on a fee-for-service basis to a capitation system (i.e., a prepaid amount of money for each patient over a specified length of time). Still other influences on today's RN-CCTM Model include the growth of health maintenance organizations (HMOs) and pilot programs of care coordination for disabled Medicaid populations. More recently, new legislation has spurred CCTM applications to new types of managed group practices serving the general population. This confluence of phenomena serves as the launch pad for the evidence-based professional model available in the *Care Coordination and Transition Management Core Curriculum* (Haas et al., 2014).

Case Management/Care Management

Case management has a long and rich history whose seeds were planted in the development of social casework in the late 1800s. It came to greater fruition in the United States in the early 1900s in the emerging disciplines of public health nursing, and social work (Huber, 2000).

By 1990, there were two basic types of models of care management: organizational models and community-based models. The original organizational model was designed by the New England Medical Center. It is an extension of primary nursing methods and focused on the acute care hospital episode. The New England Medical Center model defined case management as a care delivery model and called it *nursing case management* (Huber, 2000). Over the years, care management has been characterized by the supervision of care or supports, monitoring the utilization patterns of high cost/high use consumers and the employment of the medical model for coordinating authorized services within a single care delivery organization (Abery, Cady, & Simunds, 2005).

The community model emanated from the Carondelet St. Mary's Community Nursing Network in Arizona. It organized bachelor- and masters-prepared nurses as care managers in a nursing HMO. They were the hub of a network of broker services that practiced beyond the acute care episode across the health care continuum. These nurses were among the first who followed the movement of high-risk clients with chronic health problems from acute care to long-term care in community settings (Huber, 2000).

However, it was the growth of HMOs in the 1990s that precipitated the widespread use of the care management approach throughout health care, insurance, and social service settings (Abery et al., 2005). The physicians and staff learned to work together, a phenomenon that is the basis of care coordination and transition management.

Growth of Health Maintenance Organizations (HMOs)

HMOs are prepaid group practices that provide both health care insurance and health care services. They date back to circa 1930 and grew slowly over the following four decades due largely to strong opposition from the medical establishment. However, they attracted enrollees because of low out-of-pocket costs and their emphasis on health promotion and illness prevention.

The enactment of the Health Maintenance Organization Act of 1973 (PL 93-222) provided major impetus for HMO growth (Social Security Administration, 1974). The Act provided funding to assist in establishing and expanding HMOs, superseding state laws that restricted the establishment of prepaid health plans, and it required employers who had over 25 employees and offered health insurance as a benefit to include an HMO option. "The purpose of the legislation was to stimulate greater competition within healthcare markets by developing outpatient alternative to expensive hospital-based treatment" (National Council on Disability, 2013, p. 1). However, in the following decade, HMOs still grew slowly due to the ongoing opposition of the medical community and HMO regulatory restrictions by individual states. But the escalation of health care costs forced the government to consider new paradigms.

In an innovative move, the government authorized Medicare payments for kidney dialysis clinics and procedures performed on an outpatient basis. This spurred the formation of physician group practices that specialized in diagnostics, surgery, rehabilitation, and other services previously performed only in hospitals. The opposition of medicine to managed care plans softened as they began to understand the financial and health benefits of managed care practices.

During the late 1980s and early 1990s, managed care plans were further credited with restricting costs. Their reputation for reducing costs through

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managed care practices resulted in higher enrollments. By 1993, they covered 51% of Americans receiving health insurance through their employer (National Council on Disability, 2013).

With general health care changing and learning new ways to manage care, the government began to focus on the soaring costs of providing health care and improving outcomes for Medicaid populations with disabilities.

Care Coordination for Populations with Disabilities

In the 1990s, Medicaid became highly concerned with the poor health outcomes and high costs of caring for children and adults with disabilities. State Medicaid agencies began to search for ways to improve care outcomes while reducing costs (Abery et al., 2005).

A combination of funds from the Centers for Medicare and Medicaid Services and private foundations established pilot programs in seven states. These pilot programs were community-based agencies made up of teams of health care professionals that coordinated the care of Medicaid recipients with disabilities. Each pilot agency developed its own model of care coordination that had unique configurations of teams of advanced nurse practitioners, registered nurses, social workers, and unlicensed personnel. All functioned under a medical director. Funding was usually allocated on a capitated basis, but some plans received additional fee-for-service funding for select benefits. Capitation granted care coordinators the option to flex the benefits (i.e., the benefits could be tailored to meet patients' individual needs) (Palsbo & Mastal, 2006).

In the pilot agencies, the teams consisted of nurses, social workers, and unlicensed personnel who coordinated care. These teams were partners with the enrollees, acting as advocates for benefits to meet each person's unique needs. They formed the communication link with physicians and other community providers, updating them regarding patients' status and outcomes. As a result, the programs were successful in reducing costs and improving the health status and quality of life of enrollees (Palsbo & Mastal, 2006). Several of the pilot agencies became very innovative and made real differences in enrollees' lives by minimizing the effects of their chronic disease and enhancing the individual's ability to improve the management of their health issues. Further, they reduced unnecessary costs and built collaborative bridges among different types of community health care professionals (Mastal, Reardon, & English, 2007).

Embracing Care Coordination: Visions for the Future

In the 21st century, health care costs continued to rise and the numbers of people without health care insurance increased. Further, technology supported the collection of data that enabled providers and payers to realize that a small percentage of persons with chronic, complex conditions consumed a high proportion of health care resources. It was obvious that chronic conditions are expensive to treat and a major driver of health care spending (Thorpe, 2013). Those who struggle with multiple illnesses combined with social complexities (e.g., mental health, substance abuse, social isolation, and homelessness) find it difficult to navigate the complex, fragmented American health care system (Craig, Eby, & Whittington, 2011).

Additionally, the Affordable Care Act of 2010 includes provisions that require individualized written "plans of care and follow up plans that move with patients longitudinally over time... Care coordination has become an innovative patient-centric interprofessional collaborative practice care delivery model that integrates the registered nurse as care coordinator and transition manager" (Haas et al., 2014, p. 3).

RNs have the knowledge and expertise to serve as the pivotal agent of the interprofessional health care team, communicating with and educating patients and caregivers, as well as all stakeholders within the system and across the continuum of care.

II. Definitions of Care Coordination and Transition Management

Although care coordination and transition management are intimately entwined, they are defined separately here to optimize understanding the meaning of each and identify how they are related.

Care Coordination 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., 2007; McDonald et al., 2011, p. 4).

Transition Management Definition

A critical element inherent in care coordination is transition management, which is 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 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 (Haas, Swan, & Haynes, 2014, p. 3).

The processes of care coordination and transition management (Coleman & Boult, 2003, p. 556)

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necessitate professional assessment, patient risk identification and stratification, and identification of individual patient needs and preferences that require:

- Interprofessional collaboration and teamwork;
- Evidence-based care delivery;
- Patient and/or caregiver activation and empowerment;
- Utilization of quality and safety standards;
- Ability to work independently in the domain of nursing to identify and access community resources that meet individual, group, or population needs.

The Conceptual Basis of the RN-CCTM Model

Other models such as the Chronic Care Model (Wagner, 1998) and a Logic Model (Haas & Swan, 2014) guided the development and organization of the RN-CCTM model. The RN-CCTM model was developed as part of work by ambulatory care nurse leaders and expert panels that were sponsored by AAACN. The RN-CCTM model facilitates standardization of CCTM roles in ambulatory care as well as in acute, subacute and home health care settings. It was developed based on evidence from interprofessional literature on CCTM.

III. The Chronic Care Model as Research Guide

Initially, the Chronic Care Model (CCM) (Wagner, 1998) was used to guide AAACN's translational research project where expert panels were used to search the interprofessional literature for evidence regarding CCTM. The CCM includes the essential elements whose interactions encourage high quality chronic disease care. These elements include: the community; the health system; self-management support; delivery system design; decision support; and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise" (Improving Chronic Illness Care, 2006). The CCM can be applied to a variety of health states in multiple health care settings for targeted populations. The goals are improved patient outcomes, optimal patient/provider interactive experience, and cost effectiveness. The CCM also informed the development of methods in the RN-CCTM model to use when communicating with patients, families, communities, and the interprofessional team and health agencies across the care continuum.

IV. The Logic Model as a Connection Tool

Secondly, the Logic Model served to illustrate the connections among dimensions and competencies illustrated in the RN-CCTM model and activities, interprofessional participants, and short-, medium-, and long-term outcomes (Haas et al., 2014, pp. 10-11).

AAACN initially developed and encourages the ongoing expansion of the RN-CCTM Model as the framework for RNs performing CCTM. Care coordination and transition management have long been a dimension of the professional nurse role especially in ambulatory care (Haas et al., 1995). However, CCTM activities conducted by professional nurses in ambulatory settings have often been invisible because charting or documentation in ambulatory care settings by nurses was not routinely required. Also, CCTM is within the scope of practice of other health care providers such as advanced practice registered nurses, physicians, pharmacists, and social workers.

Although other professionals also practice CCTM, it is the RN who has the knowledge and expertise to serve as the pivotal agent of the interprofessional health care team by collaborating with internal team members, leading teams, educating patients and caregivers, as well as communicating with all stakeholders within the system and across the continuum of care.

V. RN-CCTM Model

The RN-CCTM model contains two major elements for its application. First, it lists the dimensions or competencies that are essential to CCTM. These include (Haas et al., 2014, p. 9):

1. Support for self-management;
2. Advocacy;
3. Education and engagement of patient and family/caregivers;
4. Cross setting communication and transition;
5. Coaching and counseling of patients, families, and caregivers;
6. Application of the nursing process;
7. Population health management;
8. Teamwork and collaboration
9. Patient-centered care planning.

Secondly, it uses the Logic Model to link these competencies with activities, participants, and outcomes (see Figure 1).

VI. Defining Characteristics of Registered Nurses (RN) in the CCTM Role

RNs practicing in the CCTM role (adapted from AAACN, 2011; Haas et al., 2014) exhibit the following characteristics:

1. Demonstrate knowledge, skills, and attitudes requisite to the RN-CCTM dimensions.
2. Practice across the care continuum in a variety of settings, such as acute, subacute, and Patient Centered Medical Home settings such as medical offices, Accountable Care Organizations (ACOs), freestanding health clinics, nurse-managed clinics, ambulatory surgery centers, the patient's home, telehealth service environments, care coordination organizations, comprehensive health care systems, and community health care resource agencies.

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Standard 5
Implementation

Standard

The RN practicing CCTM implements the identified plan of care to attain expected outcomes in selected groups or individuals.

Competencies

CCTM nurses:

1. Demonstrate ability to independently implement effective, population-based nursing interventions across the health care continuum that incorporate evidence-based practice guidelines, state and regulatory agency standards, and organizational policies and procedures.
2. Prioritize interventions based on an individual or population's condition, situation, and needs along the health care continuum within organizational and regulatory requirements to attain expected outcomes.
3. Implement plans along the health continuum utilizing the unique knowledge, skills, and competencies required to track, promote, maintain, restore health, or support end-of-life situations.
4. Utilize competent, evidence-based nursing interventions during care coordination processes, with an emphasis on medical home/outpatient settings according to regulatory guidelines and organizational requirements.
5. Provide population- and age-appropriate care in a compassionate, caring, and culturally and ethnically sensitive manner.
6. Collaborate with the interprofessional health team across health care settings to effectively implement population or individual care coordination plans while maintaining privacy, fiscal accountability, and individual patient advocacy.
7. Actively acquire skills with electronic technology used to document plans, care processes, team and patient communication, and patient and organizational outcomes.
8. Utilize available technology such as electronic health records (EHRs), as well as health plans, and organizational, state, and/or regulatory electronic and other communication formats and databases to attain expected outcomes.
9. Ensure that documentation of CCTM interventions and outcomes are in the applicable records and tracking systems.

Additional Competencies for Nurse Executives, Administrators, and Managers

CCTM nurse executives, administrators, and managers:

1. Establish organizational systems that ensure implementation strategies are consistent with evidence-based practice guidelines, state and regulatory agency standards, and organizational policies and procedures.
2. Facilitate staff participation in decisions to improve population health interventions and interprofessional communication.
3. Collaborate with organizational and professional peers to improve electronic information systems and interprofessional communication formats that address health needs and improve outcomes of assigned populations of patients.

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