American Academy of Ambulatory Care Nursing

Many settings. Multiple roles. One unifying specialty.

Care Coordination and Transition Management (CCTM)

Press Kit

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CCTM nurses help patients get the right care, at the right time, by the right provider.

Contents

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What is Care Coordination and Transition Management (CCTM)?

Our health care system is complex and often difficult for patients to navigate. Care coordination and transition management (CCTM) partners the health care team with patients and families to get the right care, at the right time, by the right provider. With CCTM, patients get help deciding which specialist to use, choosing where to go for care, and setting up appointments. They also get guidance about tests, procedures, medications, and follow-up care.

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.

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. This helps patients save money and avoid time away from family and work. In the long run, CCTM nurses are a crucial 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

- In America, 6 in 10 adults have a chronic disease and 4 in 10 have two or more ongoing illnesses.[1]
- 90% of the nation's $3.5 trillion in annual health care expenditures are for people with chronic and mental health conditions.[2]

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 health care 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"

References

1. Centers for Disease Control and Prevention. *Chronic Diseases in America.* Retrieved 1/29/20 from https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

2. Centers for Disease Control and Prevention. *Health and Economic Costs of Chronic Diseases.* Retrieved 1/29/20 from https://www.cdc.gov/chronicdisease/about/costs/index.htm

AAACN Resources

Care Coordination and Transition Management (CCTM) Core Curriculum, 2nd Edition, 2019 serves as the foundational reference for CCTM RN practice and is an educational resource for undergraduate and graduate nursing students and currently practicing registered nurses.

Care Coordination and Transition Management Scope and Standards describes the role and the standards of practice for the RN practicing CCTM in a variety of settings.