American Academy of Ambulatory Care Nursing

Many settings. Multiple roles. One unifying specialty.

Care Coordination and Transition Management (CCTM) Resources

- AHRQ: Care Coordination definition and additional information on care coordination. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

- Quality and Safety Education for Nurses (QSEN) National nursing competencies and their knowledge, skills, and attitudes (KSAs) of their expected behaviors are embraced by nursing undergraduate and graduate educators. http://qsen.org/

- Patient Aligned Care Teams (PACT) PACT is the Models of Care transformation in which Veterans receive their care, by providing patient-driven, proactive, personalized, team-based care oriented toward wellness and disease prevention resulting in improvements in Veteran satisfaction, improved healthcare outcomes and costs. The PACT model is built on the well-known concept of the patient centered medical home staffed by high-functioning teams.
  http://www.va.gov/health/services/primarycare/pact/index.asp

- Guided Care Model: A model driven by a trained **Guided Care** nurse who works with three to four physicians in a primary care office and provides high-quality chronic care to their patients. http://guidedcare.org/

- Transitional Care Model is an evidenced-base model to assist and manage the health problems of the elderly patients with multiple health problems, as they move from hospital to home.
  http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx

- The Care Transitions Program and Care Transitions Interventions, under the leadership of Eric Coleman M.D.
  http://www.caretransitions.org/

- Better Outcomes by Optimizing Safe Transitions (BOOST): A national initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to home. Project BOOST has developed tools to assist in transitions. http://www.hospitalmedicine.org

- Geriatric Resources for Assessment and Care of Elders (GRACE): A team-developed care plan to improve the quality of geriatric care and optimize health and functional status, decrease excess health care use, and prevent long-term nursing home placement. *Journal of the American Geriatrics Society*
  http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2006.00791.x/abstract

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- Re-Engineered Discharge (Project Red): A training program that is a patient-centered, standardized approach to discharge planning designed to help hospitals re-engineer their discharge process. Project RED (Re-Engineered Discharge) http://www.bu.edu/fammed/projectred/

- The Chronic Care Model (CCM) developed by the MacColl Institute: The CCM identifies elements of a health care system considered essential to encourage quality care for chronic disease. http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
- ANA: Web page for Care Coordination and the Essential Role for Nurses http://www.nursingworld.org/care-coordination

Learn about these Care Coordination and Transition Management resources available through AAACN at:

https://www.aaacn.org/practice-resources/cctm

- *Care Coordination and Transition Management Core Curriculum*
- *Scope and Standards of Practice for Professional Care Coordination and Transition Management*
- *Care Coordination and Transition Management Review Questions* (to assist nurses in preparing for the CCTM certification exam)*
- Care Coordination and Transition Management Certification Exam developed through a collaboration with the Medical-Surgical Nursing Certification Board

* *Expected availability March 2016*