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A Competency Model to Improve Quality and Safety, Care Coordination, and Transitions

Health care delivery involves a complex combination of processes, technologies, and human interactions, with an inevitable risk of adverse events. Despite rigorous efforts to improve health care quality and safety, preventable harm continues to be a global concern (National Academies of Sciences, Engineering, and Medicine [NASEM], 2018). Culture changes, organizational commitment, and redesign of education and training are necessary to develop health care teams with the competencies to design and lead high-reliability organizations – those with a focus on evidence-based care standards to improve safety.

The second edition of the *Care Coordination and Transition Management Core Curriculum* provides an update in the continuing efforts to improve patient care outcomes by defining a competency model integrating the Quality and Safety Education for Nurses (QSEN) competencies with standards from the American Academy of Ambulatory Care Nursing (AAACN). This book integrates the QSEN competencies (person-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics) (Cronenwett et al., 2007) with the nine Care Coordination and Transition Management Registered Nurse (CCTM RN®) dimensions: self-management, individual/family education and engagement, communication and transition, population health management, coaching and counseling individuals and families, nursing process, teamwork and collaboration, person-centered care planning, decision-support and information systems, and advocacy.

As health care continues to evolve, both in delivery and economic forces, more attention is focused on improving outcomes. As patients transition across care settings, whether between acute and primary care, ineffective collaboration between care team members contributes to fragmented care. In primary and ambulatory care, the relationship between the clinician and the individual is a key to high-quality, safe, and effective health care (Agency for Healthcare Research [AHRQ], 2017) by implementing evidence-based strategies to improve patient outcomes by engaging individuals and families in their care.

By practicing to their fullest educational preparation, nurses are uniquely positioned to provide key leadership in improving care management across a myriad of care delivery settings (Institute of Medicine [IOM], 2010), but need guidelines that address specific settings and populations. Competency-based nursing education and professional practice models utilize the knowledge, skills, and education defining what nurses need to know, what they need to be able to do, and the values and beliefs that guide their actions. Standardized care objectives guide nursing actions, and address quality and safety concerns, which were first described in 2000 (IOM, 2000), as well as the subsequent quality goals (IOM, 2001) from STEEEP, an acronym for making sure all care is Safe, Timely, Equitable, Efficient, Effective, and Patient-centered (IOM, 2002). Still, however, the 2018 global quality report, "Crossing the Global Quality Chasm: Improving Health Care Worldwide" (NASEM, 2018), discloses continuing gaps in care reliability.

Three care coordination and transition management experts who are each Past Presidents of AAACN guided development with a futuristic perspective that provides a critical step in improving quality and safety of care by helping nurses understand better how to incorporate the QSEN and CCTM RN competencies in practice. Person-centered care is at the heart of safety; CCTM standards describe specific, evidence-based standards for accurate and personalized assessment as the basis for person-centered care. Safety awareness is even more important in considering unique practice settings that include advanced practice nurses, who may be in independent or group practice; nurses who must communicate and share care goals among interprofessional colleagues; those who manage small care teams; or nurses who supervise unlicensed personnel. Recognizing breakdowns in processes is the first step to develop quality improvement initiatives that can close gaps between ideal and actual performance measures. Competency in informatics provides a key strategy for communication, decision support, and documentation.

The power of this book is making care standards readily accessible to nurses. Standardization in care is a major component of safe care. Evidence-based standards share best practices based on the latest evidence gathered from the literature and documented experiences. Standardized handover processes and communication can assure care management without interruption. Nurses are the constant care providers who spend the most time with individuals; therefore, nurses have key information for making reliable

care decisions. Sharing accurate and timely information between providers can reduce errors during transitions in care. Knowing when and how to speak up is critical for improving care outcomes, and knowing the essential standards can inspire confidence.

Competency models also provide measurement criteria for assessing competency achievement and clinical judgment. Reflection is a key component of competency models when thinking about how to improve one's work and developing awareness of the context of practice (Tanner, 2006). Competency development is more than achieving skills or completing tasks; a competency-based practice model guides organization of tasks within a person-centered perspective to address needs in a particular care delivery setting, such as nursing in an ambulatory care center or a specific patient population. Competency statements identifying the knowledge, skills, and attitudes are essential guides for educational curricula or specific training, licensure and certification requirements, position descriptions, personnel recruitment, and/or employee performance review.

The comprehensive nature of these competencies can leverage improvements across all settings and providers, and can be applied in multiple ways from orientation to evaluation. These evidence-based competencies are about empowering nurses to address unmet needs of the delivery system to give them tools to empower individuals applying the change model of *Will, Ideas, and Execution* (Philips, 2017). We know that nurses have the *will* to improve care when they have the *ideas* and the resources for *execution.* The *Care Coordination and Transition Management Core Curriculum, 2nd Edition,* is a vital resource for all nurses who fit the current practice arena and has the capacity to improve care for all. This second edition helps nurses navigate the ever-evolving health care delivery system, and economic provisions, diversity and the social determinants of health, and increasing comorbidities in complex ambulatory care settings. Finally, this second edition provides an updated roadmap to improve health care quality and safety, particularly in transitions across all care settings and providers.

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Introduction

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Learning Outcome Statement

After completing this learning activity, the learner will be able to describe the background and significance of the Care Coordination and Transition Management registered nurse (CCTM® RN) Model.

I. Purpose

In September 2017, the AAACN Board of Directors approved the revision/update of the *Care Coordination and Transition Management Core Curriculum* (2014) due to the rapidly changing evidence in care coordination and transition management. The *CCTM Core Curriculum* text serves as the foundational reference for Care Coordination and Transition Management Registered Nurse (CCTM® RN) practice in all settings across the health care continuum and is an educational resource for nursing education curriculum, as well as currently practicing registered nurses. In addition, the CCTM Core Curriculum text is a resource for the Certified in Care Coordination and Transition Management (CCCTM®) certification. AAACN materials include:
- *Scope and Standards of Practice for Registered Nurses in Care Coordination and Transition Management* (2016).
- *Care Coordination and Transition Management Review Questions* (2016).
- *The Role of the Registered Nurse in Ambulatory Care Position Paper* (2017).
- Care Coordination and Transition Management Online Courses (e.g., CCTM 1, CCTM 2); Care Transition Hand-Off Toolkit.
- Care Coordination and Transition Management Toolkit, which utilizes current evidence-based strategies and best practice exemplars to describe how to educate the CCTM RN to enhance the role, build CCTM services, and develop outcome measures in various practice settings. Additional information sources include the American Association of Colleges of Nursing's (AACN) Vision for Nursing Education (2018) and the AACN baccalaureate, masters, and doctoral essentials currently being updated.

II. History

During the summer of 2011, the 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 CCTM RN role. The Advisory Team developed a survey asking members if they had access to CCTM competencies, and if not, did they feel there was a need for them.

In July 2011, AAACN members were asked to complete the 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 that competencies needed to be evidence-based and thorough to support the care provided to individuals 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: "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 AAACN 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.

III.   Vision for the Core Curriculum as the Foundation for the CCTM Model

A. Vision.
1. The CCTM RN Model standardizes the work of all health care providers in all settings, using evidence from interprofessional literature on CCTM.
2. The CCTM RN Model.
    a. Specifies the dimensions of CCTM and the associated competencies needed to be performed within the CCTM RN Model.
    b. Defines the knowledge, skills, and attitudes needed for each dimension.
    c. Meets the needs of individuals with complex chronic illnesses (and their families) being cared for in their homes, patient-centered medical homes (PCMH), as well as traditional and non-traditional acute and outpatient settings.
    d. Meets the needs of care for individuals with complex health and social needs (Humowiecki et al., 2018).
    e. Recommends that RNs educated and prepared to work as a CCTM RN be recognized by a certification credential and reimbursed by the Centers for Medicare & Medicaid Services (CMS).
3. Consistent with the Institute of Medicine's (IOM) report, *The Future of Nursing: Leading Change Advancing Health* (Altman, Butler, & Shern, 2015; IOM, 2010), the CCTM RN 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 policy making 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.

IV.   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. In 2008, the American Nurses Association (ANA) 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 judgment. The integration of knowledge, skills, abilities and judgment occurs in formal, informal, and reflective learning experiences" (ANA, 2008, p. 2). Arriving at consensus on a definition of competence is still a challenge.
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 marshaling 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).
2. National Quality Forum (NQF) (2010) 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" (p. 2).

3. NQF (2016) updated definition: Care coordination is "the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for health care and community services are met over time" (p. 13).

C. Transitional care versus 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 as defined by Naylor and Sochalski (2010) 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 individuals 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" (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 return 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 & Boult, 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 & Boult, 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 individual's goals, preferences, and clinical status.
      b. It includes logistical arrangements, education of the individual and family, and coordination among the health professionals involved in the transition.
      c. Transitional care, which encompasses both the sending and receiving aspects of the transfer, is essential for persons with complex care needs (Coleman & Boult, 2003).
   4. The authors expanded on these terms and definitions of transitional care and care transitions to the term *transition management*. The authors define transition management in the context of RN practice in multiple settings as the ongoing support of individuals 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 individuals' and/or families' needs for support for ongoing, longitudinal evidence-based, individualized plans of care and follow-up plans of care within the context of health care delivery (Haas, Swan, & Haynes, 2014).

D. CCTM.
   1. In all practice settings across the health care continuum and the community,

CCTM are integrated functions that may occur simultaneously or separately, and are not time-limited as defined above. One provision of the 2010 Affordable Care Act (ACA) to support this expanded definition is the need for individualized evidence-based plans of care and follow-up plans of care that move with individuals longitudinally over time.

2. Individualized evidence-based plans of care and follow-up plans of care serve as the basis for the CCTM RN model, an innovative person-centered interprofessional collaborative practice care delivery model that integrates the RN role as care coordinator and transition manager (Swan & Haas, 2011).

3. CCTM RN model recognizes the care coordination and transitional care activities performed by RNs and interprofessional team members in all practice settings across the health care continuum and the community.

E. Confusion over differences between existing care models and the CCTM RN Model.

1. Many health care professionals assume that case management and nurse navigator roles are the same as CCTM. Both models were developed in the past to meet regulatory and individual needs for guidance in an increasingly complex care system. The CCTM RN role includes activities in case management and navigation, but case management and navigation are singular interventions and do not encompass all CCTM RN Model dimensions and activities/interventions. CCTM was developed through a scientifically sound Translational Research project. The activities/competencies within each of the nine CCTM dimensions are evidence-based and comprehensive.

2. *Case management* is defined as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management, and promotes quality and cost-effective interventions and outcomes (Commission for Case Manager Certification, 2018).

    a. Focus in case management is the individual plan of care versus the CCTM focus on population health management and the use of evidence-based population guidelines, such as those for hypertension and heart failure, to guide the development of individual plans of care that are then modified to reflect individual goals, values, and preferences.

    b. Another focal area of case management is utilization review.

3. "Oncology nurse navigator: An oncology nurse navigator (ONN) is a professional RN with oncology-specific clinical knowledge who offers individualized assistance to patients, families, and caregivers to help overcome healthcare system barriers. Using the nursing process, an ONN provides education and resources to facilitate informed decision making and timely access to quality health and psychosocial care throughout all phases of the cancer continuum" (Oncology Nursing Society, 2017, p. 4).

    a. The ONN role is focused on education and support of persons and families need for informed decision making and timely access in all phases of the cancer continuum. The competencies of an ONN are included within the nine CCTM RN dimensions. A CCTM RN who works with oncology patients would develop specific expertise with oncology populations as they would with other patient populations such as those with diabetes and heart failure.

V. Background and Significance of the 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 (AHRQ, 2010; McDonald et al., 2011).

    b. Chronic diseases are responsible for seven out of 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation's health care costs (Centers for Disease Control and Prevention [CDC], 2018).

    c. Eighty-eight percent of U.S. health care dollars are spent on medical care that only accounts for approximately 10% of a person's health. Other determinants of health are lifestyle and behavior choices, genetics, human biology, social determinants, and

Advocacy

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Learning Outcome Statement

After completing this learning activity, the learner will be able to define and describe the dimension of advocacy as an important element of the Care Coordination and Transition Management (CCTM®) model.

Learning Objectives

After reading this chapter, the CCTM registered nurse (RN) will be able to:
- Demonstrate person advocacy in all CCTM activities.
- Describe the application of professional practice standards to the CCTM role.
- Discuss the concept of person advocacy as it relates to ethical principles in nursing.
- Describe a plan of care developed in collaboration with the individual and family that reflects advocacy needs, interventions, and outcomes.
- Explain the importance of addressing behavioral and mental health needs of individuals, families, and populations.
- Discuss how social determinants of health impact the overall wellbeing of individuals, families, and communities.
- Describe the effects of health literacy on the health of individuals, families, communities, and populations.
- Discuss the importance of advocacy in the care of children.
- Discuss the importance of CCTM nurses' participation in organizational and public policy formation.
- Describe ways in which nurses can practice advocacy by working to influence policy development at the organizational, local, regional, state, or national level on behalf of individuals, families, and the profession of nursing.
- Describe leadership behaviors related to CCTM.
- Demonstrate the knowledge, skills, and attitudes required for the advocacy dimension (see Table 2-1 on page 43).

AAACN Care Coordination and Transition Management Standards

Standard 1.	Assessment
Standard 3.	Outcomes Identification
Standard 4.	Planning
Standard 5.	Implementation
Standard 5a.	Care Coordination
Standard 5b.	Health Teaching and Health Promotion
Standard 6.	Evaluation
Standard 7.	Ethics
Standard 8.	Education
Standard 9.	Research and Evidence-Based Practice
Standard 10.	Performance Improvement
Standard 11.	Communication
Standard 12.	Leadership
Standard 13.	Collaboration
Standard 15.	Resource Utilization
Standard 16.	Environment

Source: AAACN, 2016.

Competency Definition

Advocacy in nursing practice is a process that involves a series of strategies and actions for preserving, representing, and/or safeguarding the best interests and values of individuals, families, and populations within the health care system (Bu & Jezewski, 2007; Water, Ford, Spence, & Rasmussen, 2016).

Systems level advocacy in nursing refers to nurses' actions that promote health broadly at a systems level by remaining focused on the context of the health care delivery system and policymaking at the organizational, local, state, and national levels (Water et al., 2016).

Medical science, technology, and the U.S. health care system have evolved rapidly over the past decade. This has brought continuous change in health care delivery systems and the policies that support them. Today's health care involves multiple disciplines and rapid turnover, which often leaves individuals and families moving between services, providers, specialties, departments, and locations, while having only brief contact with a number and range of health care professionals. Despite good intentions, health-related services may be fragmented and information difficult to access and understand, resulting in confusion and difficulty making decisions (Choi, 2015). These factors have led to the critical need for care coordination by registered nurses (RNs) working within interprofessional teams to assist individuals, families, and populations in negotiating and navigating health care systems. Although the importance of advocacy in nursing practice is widely recognized, the concept is not universally defined, nor are the processes, strategies, or activities that compose its framework (Bu & Jezewski, 2007). At the individual and family level, there is agreement that humanistic relationships between the nurse and the individual/family are the foundation for integrating advocacy into practice (Choi, 2015; Water et al., 2016). *The Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association [ANA], 2015) delineates the role of advocacy at the individual, organizational, and system levels. To practice effectively, nurses in care coordination and transition management (CCTM®) require an understanding of the meaning and importance of advocacy in professional nursing practice. This chapter will focus on the dimension of advocacy as it relates to the CCTM RN model. In addition, the chapter includes an in-depth discussion of several areas of health care closely related to and affected by the practice of advocacy, including behavioral/mental health, social determinants of health, and health literacy.

I.   Advocacy in Nursing Practice

Nursing theorists have continued to work toward a common description of advocacy in nursing practice. Bu and Jezewski (2007) summarized the evidence related to nursing advocacy published between 1974 and 2006 (Bu & Jezewski, 2007).

A. Three core attributes of the concept of advocacy were identified.
1. Assuring individual autonomy and self-determination.
2. Acting on behalf of individuals.
3. Championing social justice in health care.

B. Antecedents of advocacy in health care are described by the context (level) of care in which they occur.
1. Microsocial level. Refers to advocacy directed toward individuals, families, or groups. Antecedents of advocacy at this level include:
    a. Vulnerability. Refers to individuals or groups who are unable to protect their own needs and rights or to make decisions due to:
        (1) Language or literacy issues.
        (2) Learning disabilities.
        (3) Socioeconomic status.
        (4) Minority status.
        (5) Conditions.
             (a) Unconsciousness.
             (b) Mental illness.
             (c) Advanced disease processes.
    b. Lack of confidence in health-related decision-making, which creates a need for nursing intervention in support of the individual right of self-determination.
2. Macrosocial level. Refers to advocacy directed toward a population, organization, or society in general. Antecedents of advocacy at the macro level include:
    a. Health disparities related to:
        (1) Minority populations.
        (2) Socioeconomic status.
    b. Complexity of health care system, including:
        (1) Advanced technology.
        (2) Health care costs.
        (3) Complexity of changing health care policies.
    c. Contributing societal factors, including:
        (1) Access to health care services.
        (2) Poverty.
        (3) Cultural barriers.
        (4) Racism.
        (5) Health literacy.
C. Outcomes evaluation of advocacy (Choi, 2015).
1. At the microsocial level, positive outcomes of advocacy suggest the rights, values, well-being, and best interests of individuals and families have been upheld through the advocacy practices of the nurse.
    a. Individuals and families receive adequate information.
    b. Health care professionals with specific expertise are involved directly.
    c. Views of the individual/family are accurately relayed to the health care team.
    d. Individuals' rights to decision-making are respected.

Figure 2-1.
Advocacy
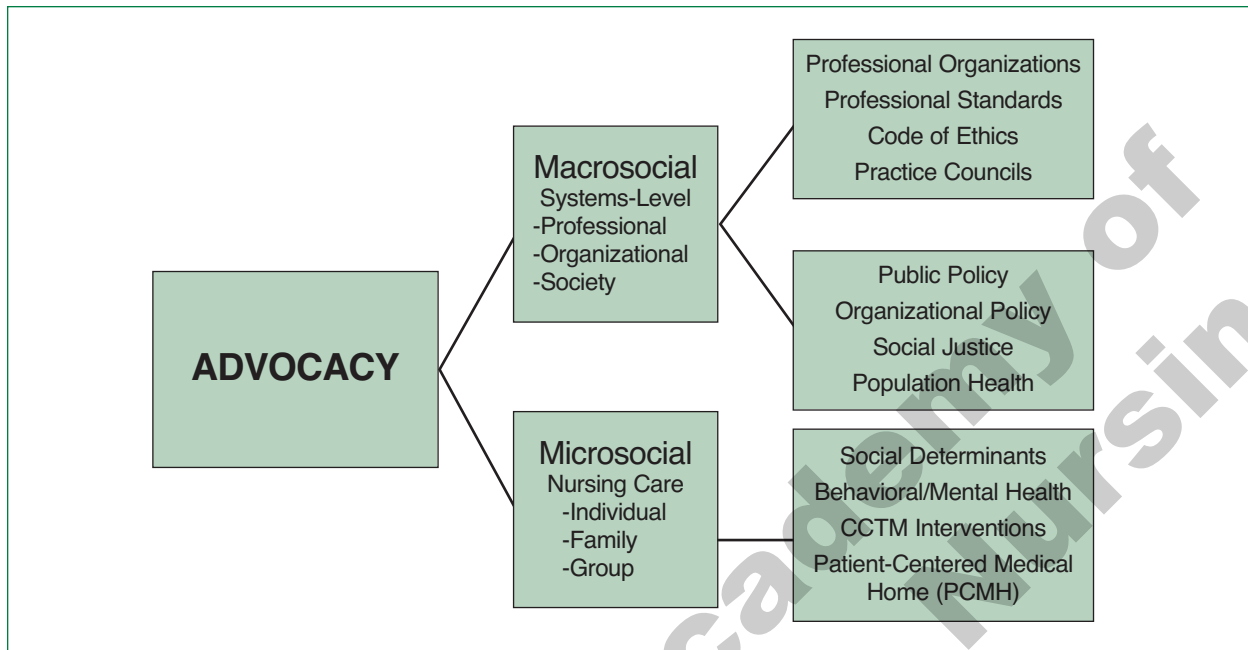
2. At the macrosocial level, positive outcomes suggest advocacy practices of nurses have resulted in desirable changes in health care policies and well-being of the organization, community, society, and the nursing profession.
   a. Improvement in access to services.
   b. Measureable improvements in population health.
   c. Enhanced public image of nurses.
   d. Increased satisfaction and autonomy of nurses (see Figure 2-1).

II. Ethics in CCTM Nursing

Because nursing exists to offer care and support to society at varying levels, ethical issues and questions are an inherent element of the profession. CCTM RNs are in a unique position of influence by virtue of their roles as caregivers and advocates. CCTM RNs often form close relationships with individuals, families, and communities, and therefore, observe and experience their life stories. Milliken and Grace (2017) describe ethical nursing care as those actions taken by nurses to address needs that are in accordance with the profession's goals and perspectives. CCTM RNs should be aware of those areas of their practice that are central to ethical standards (Milliken & Grace, 2017). The development of ethical sensitivity and decision-making skills is as important in day-to-day CCTM practice as it is in more obvious ethical situations (Grace & Milliken, 2016).

A. Ethical sensitivity.
   1. Begins with an awareness of the ethical implications of all actions in nursing practice.
   2. Ethical sensitivity is the first step in developing moral reasoning and moral agency.
B. Moral agency.
   1. Refers to ethical obligations inherent in nursing practice as established in professional codes of ethics.
   2. Involves the willingness and ability to take action on behalf of individuals and groups for the purpose of bringing about positive change.
   3. Is important in achieving individual and population health-related goals, as well as in preventing adverse outcomes.
C. Moral action.
   1. Achieved through the development of ethical awareness, moral agency, and ethical decision-making skills.
   2. Elements of moral action include:
      a. Problem analysis.
      b. Mediation.
      c. Effective communication.
D. Moral distress.
   1. Describes a temporary or repeated sense of uneasiness caused by one's inability to stop a perceived harm or carry out a beneficial action on behalf of another.
   2. Occurs when nurses recognize the actions to take but are constrained from taking

them.

3. Can lead to feelings of powerlessness, but importantly, can also lead to activism, a form of advocacy.
4. Can be mitigated by nurses working within their organizations to promote ethical sensitivity and decision-making in day-to-day practice.

> Ethical sensitivity begins with an awareness of the ethical implications of all actions in nursing practice.

E. ANA's (2015) *Code of Ethics for Nurses with Interpretive Statements* establishes ethical standards for professional nursing in the United States. An ethical code provides professional self-regulation and accountability, defines client-professional obligations and peer relationships, and serves as a resource for analysis, decision, and action. The Code is applicable in all settings in which nurses practice. This important document outlines the values, moral norms, and ideals that guide nurses and nursing organizations. CCTM RNs are expected to embrace these ethical standards in all nursing actions. The Code should also inform all aspects of life, both personal and professional (ANA, 2015). The following provisions of the Code of Ethics for Nurses are specifically and directly applicable to the advocacy dimension of the CCTM model:
 1. The CCTM RN practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
    a. Relationships with individuals.
       (1) CCTM RNs establish trusting relationships with individuals and families.
       (2) Individual factors are considered in establishing plans of care.
          (a) Culture.
          (b) Value systems.
          (c) Spiritual beliefs.
          (d) Social support systems.
          (e) Gender and sexual orientation considerations.
          (f) Communication and language.
    b. The right to self-determination refers to the individual's right to determine what will be done with and to their own person.
       (1) Individual rights are both moral and legal.
       (2) Information must be presented accurately, completely, and in a manner understandable to the individual and family.
          (a) CCTM RNs assess the individual's understanding of the information presented.
          (b) Self-determination is dependent on awareness of the decision and can be impacted by cognitive ability, literacy, language proficiency, educational level, visual or hearing impairment, anxiety, or fear.
       (3) Information must be provided in a manner that facilitates informed decision-making.
       (4) Individuals must be assisted with weighing available benefits and risks related to available options in treatment.
       (5) Individuals have the right to accept, terminate, or refuse treatment without coercion or deceit.
       (6) Individuals and families must be provided with support throughout the decision-making and treatment process.
          (a) CCTM RNs include family members and significant others in decision-making, as desired by the individual.
          (b) CCTM RNs include other expert and knowledgeable nurses and other health care providers in decision-making.
 2. CCTM RNs maintain a primary commitment to the individual, family, group, community, or population. CCTM advocacy involves many levels of care and responsibility.
    a. CCTM RNs ensure that honest discussions regarding available resources and treatment options occur at all levels.
    b. CCTM RNs evaluate the capacity for self-care at individual, family, and population levels.
    c. CCTM RNs recognize and consider the individual's place within the family and other relationships.
    d. CCTM RNs value collaboration and shared decision-making, as well as participation of all appropriate health professions in coordinating care.
 3. CCTM RNs promote, advocate for, and protect the rights, health, and safety of

individuals and families.

a. CCTM RNs respect privacy and confidentiality.

   (1) Individuals have the right to control access to personal information, including disclosure and nondisclosure of personal information.

b. CCTM RNs acquire and maintain appropriate practice competencies to support professional practice.

   (1) CCTM RNs demonstrate personal integrity, relational maturity, and professional commitment.

c. CCTM RNs participate in the development, implementation, and review and adherence to organizational and professional policies that promote individual health and safety, reduce errors and waste, and sustain a culture of safety (see Section IX).

4. The CCTM RN owes the same duties to self as others.

a. CCTM RNs have a duty to take the same care for their own health and safety as that of others.

   (1) CCTM RNs should be role models of health maintenance and health promotion.

   (2) CCTM RNs should seek appropriate health care services, as needed.

   (3) CCTM RNs avoid taking unnecessary risks to their own health and safety.

   (4) CCTM RNs mitigate fatigue and compassion fatigue.

      (a) Healthy diet.

      (b) Adequate rest.

      (c) Healthy relationships.

      (d) Adequate leisure.

      (e) Spiritual needs.

5. CCTM RNs contribute to nursing and health policy development (see Section X).

6. CCTM RNs collaborate with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities (see Section V).

7. CCTM RNs integrate social justice into nursing and health policy (see Section V).

a. Justice refers to equal and fair distribution of resources.

b. Justice implies an equal right to resources, regardless of what a person has contributed or who they are (ANA, 2015).

III. Advocacy and the CCTM Standards of Practice

RNs practice advocacy when they identify with and understand the professional standards that exist to guide their practice. For CCTM RNs, the *Scope and Standards of Practice for Registered Nurses in Care Coordination and Transition Management* (American Academy of Ambulatory Care Nursing [AAACN], 2016) provide this structure. These 16 standards are organized within the domains of Clinical Practice and Organizational and Professional Performance and serve as authoritative statements that describe the responsibilities for which CCTM RNs are accountable.

A. The first six standards describe responsibilities within the Clinical Practice domain. These standards reflect the nursing process, addressing each step as it applies to the practice of nursing within the CCTM model. The following elements of these standards in particular reflect the practice of advocacy in CCTM nursing practice.

1. Standard 1: Assessment.

a. CCTM RNs perform assessments which focus on health needs as well as the unique concerns of individuals, families, groups, and populations.

b. CCTM RN executives advocate to ensure information technologies support input and retrieval of assessment data across the care continuum.

2. Standard 2: Nursing Diagnoses.

a. Prioritize nursing diagnoses based not only on an individual's physical condition, but also on personal and cultural preferences, age-specific needs, areas of risk, and psychosocial vulnerabilities.

3. Standard 3: Outcomes Identification.

a. Include input from individual, family, and/or caregiver in the process of identifying specific, concise, and measurable goals.

   (1) Prioritize goals based upon individual and family preferences and values.

   (2) Use a holistic, person-centered, evidence-based approach to achieve expected outcomes.

b. CCTM RN executives advocate for administrative guidelines that ensure