Domains of CCTM Practice

The following Domains of Nursing Practice and associated activities are based on a practice analysis of the CCTM role.
Select a Domain to learn more about its associated activities.

Advocacy - 10%
1. Support and educate patient to make informed decisions regarding their plan of care.
2. Empower patient in navigating the healthcare system for access to the appropriate care.
3. Encourage patient to build strong partnerships with healthcare team members.
4. Apply principles of professional codes of ethics to ensure individual rights.
5. Preserve patient’s rights to confidentiality, privacy, and self-determination within legal, regulatory, and ethical parameters.
6. Apply change management principles by using data to improve patient and systems outcomes, e.g., team development processes, office dynamics.
7. Address barriers to access to services for underserved, vulnerable, and at-risk populations, e.g., transportation, housing, finances, healthcare.
8. Employ communication skills including assertiveness, negotiation, and conflict resolution to promote positive health outcomes.
9. Recognize the connections among health, poverty, mental illness, and homelessness as important elements of effective practice involved in the coordinated care of impoverished, underserved, and vulnerable populations.

Communication and transition throughout the care continuum - 20%
1. Identify the services, providers, and resources to address patient needs.
2. Determine appropriate level of care.
3. Provide patient with options for providers, facilities, and services.
4. Verify all necessary authorizations from payer are completed prior to transition.
5. Ensure effective verbal and written communication among providers and care settings.
6. Provide structured hand-off reports with consistent content, e.g., SBAR, discharge check-off list.
7. Communicate transition plan of care to patient, caregiver, and support network.
8. Meet applicable regulatory communication requirements, e.g., interpreters, EMTALA, nurse licensure compact, etc.
9. Verify referral of care acceptance from one provider or service to another.
10. Ensure seamless transition while maintaining continuity of care.
11. Monitor the outcomes of the transition process.
12. Adjust the plan of care based on identified risks.
13. Use care coordination and transition models (e.g., BOOST, PAM, GRACE, Modified LACE, CTI, Ask Me 3) for assessment, risk stratification, care planning, etc.

Population health management - 20%

1. Identify target populations utilizing appropriate inclusion criteria.
2. Identify measures for risk stratification, e.g., predictive modeling, lab values, claims data, core measures (heart failure, pneumonia, SCIP).
3. Address the gaps in care for preventive services and chronic condition management.
4. Promote patient engagement, e.g., motivational interviewing, tailored coaching, self-management promotion, counseling, and incentives.
5. Create an individualized plan of care that incorporates standards of care for the particular target population.
6. Incorporate preventive, wellness, and chronic care needs in plan of care, including immunizations.
7. Utilize automated outreach systems and reminders for preventive care management.
8. Optimize information management and communication through the use of informatics and decision-support systems.
9. Integrate telecommunications technologies to increase access, improve outcomes, and contain/reduce costs of healthcare.
10. Use information management tools to monitor outcomes of care processes.
11. Stay current with emerging trends, new legislation, and payment and reimbursement models in the provision of care design and delivery in the populations managed.

Teamwork and interprofessional collaboration - 15%

1. Identify the care team participants based on patient needs.
2. Develop partnerships with patient, caregiver, and providers to create an individualized plan of care.
3. Describe strategies for identifying and managing team member roles and accountabilities.
4. Use effective professional communication skills and tools to disseminate relevant information among team members.
5. Identify processes to overcome barriers to effective collaboration and teamwork, e.g., updating scheduling information, staff education, “huddles”.
6. Utilize patient, caregiver, and support network care conferences to resolve transition conflicts to optimize the continuum of care.
7. Assist interprofessional team members to reprioritize activities according to immediate patient needs, e.g., specialty consultations, procedure delays, and equipment failure.
8. Examine strategies for improving systems to support team functioning.

Patient-centered care planning and support for self-management – 15%

1. Perform a comprehensive needs assessment.
2. Review patient’s record to identify gaps in care and individualize the plan focus.
3. Identify conditions that place patient at high risk.
4. Perform a telephonic or face-to-face visit with the patient to identify patient needs and barriers to care.
5. Assess patient’s understanding with current health status and needs.
6. Identify the patient’s short and long-term goals.
7. Incorporate patient values, goals, and preferences into planned care activities.
8. Assess patient’s understanding of chronic condition(s).
9. Determine the patient’s adaptation to illness or stressors.
10. Support knowledge and understanding of health promotion and disease prevention.
12. Incorporate care regimen into daily practices.
13. Assist the patient, caregiver and support network to self-evaluate to measure success against individualized goals.

Education, engagement, coaching and counseling of patients, caregivers, and support network - 20%

1. Assess patient’s health literacy, readiness for learning and learning style.
2. Utilize motivational interviewing techniques to engage patient.
3. Recognize the social, environmental, and cultural factors and disparities in health care in designing and implementing interventions.
4. Recognize and encourage patient, caregiver, and support network’s participation as active members of the team.
5. Develop individualized education strategies to address the plan of care and the patient, caregiver, and support network’s goals.
6. Assist patient to develop SMART goals (Specific, Measurable, Achievable, Realistic, Time-specific).
7. Identify and provide necessary resources to assist patient to achieve goals.
8. Incorporate “teach back” to monitor and evaluate patient’s level of understanding.
9. Identify barriers to adherence to the plan of care.
10. Re-evaluate and adjust the education plan as indicated.
11. Assess patient’s understanding of the disease process and plan of care.

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