المجلس التمريضي الأردني
Jordanian Nursing Council

Chronic Care Nursing

Chronic Disease Nurse Specialist and Chronic Disease Advanced Nurse Specialist: Scope of Practice, Professional Standards, Competencies, and Indicators

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The Jordanian Nursing Council

The Jordanian Nursing Council (JNC) is a national governmental regulatory institution for nursing and midwifery in Jordan. The JNC is governed by a board headed by Her Royal Highness Princess Muna Al Hussein as president of the council. The board, comprising of 14 key representatives of healthcare institutions in Jordan, regulates and governs the nursing profession in the areas of education, practice, and research.

You can access this document at www.jnc.gov.jo.

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Acronyms

CDNS	**Chronic Diseases Nurse Specialist**
CDANS	**Chronic Diseases Advanced Nurse Specialist**
JNC	**Jordanian Nursing Council**
NANDA	**North American Nursing Diagnosis Association**

Introduction

This document presents the scope of practice, professional standards, and essential competencies for chronic diseases nurse specialist (CDNS) and chronic diseases advanced nurse specialist (CDANS) in Jordan. CDNS and CDANS have distinguished themselves as effective coaches of those with chronic illness by promoting self-care and reducing the costs of the illness and readmissions. One distinguishing attribute of the CDNS and CDANS is the ongoing incorporation of the science of nursing that is based on current evidence facilitating the recognition of patterns in health behaviors in order to make changes to improve health outcomes. It is this expertise in managing patient populations, especially those with chronic conditions, that augments self-management and bridges any existing gaps in the continuity of care. Specific cost-effective competencies directed towards self-management to prevent readmissions of chronically ill patients are part of the CDNS and CDANS competency list.

Scope of Practice

There is a growing population of chronic disease globally that has raised the need for expert nurses in managing the complex and chronicity of this group of diseases. Chronic diseases nurse specialist practice aims to develop and ensure the quality of nursing care, foster the implementation of evidence-based nursing, support the hospital or health care institutions strategic plan for provision of healthcare services and providing direct and indirect healthcare services. The chronic diseases nurse specialist (CDNS) and chronic diseases advanced nurse specialist (CDANS) provide leadership in advancing nursing practice including research, policy, guidelines and procedures development and interdisciplinary education.

The scope of practice for CDNS and CDANS encompasses a specialized and comprehensive approach to the care of clients with long-term and chronic health conditions. CDNS and CDANS possess advanced knowledge, skills, and expertise in delivering, managing and supporting nursing care of individuals with chronic illnesses and their families and support persons throughout their healthcare trajectory.

The goal of CDNS and CDANS is to provide advanced nursing care that optimizes the quality of life for individuals with long-term health conditions. CDNS and CDANS healthcare professionals employ their advanced knowledge and expertise to enhance patient outcomes, promote self-management and independence, and ensure comprehensive and quality patient-centered care. Through their expertise, advocacy, and compassionate approach, CDNS and CDANS make a significant impact on the lives of individuals and families living with chronic illnesses, empowering them to live their lives to the fullest despite the challenges they face.

CDNS and CDANS are expected to provide individualized care for clients with a wide range of chronic health conditions. Examples of chronic illnesses and health conditions may include diabetes, hypertension and heart failure, chronic respiratory diseases, cancer, inflammatory bowel diseases, and chronic renal diseases. Their clinical practice includes health promotion, risk reduction, and management of symptoms and functional problems related to chronic disease and illness, and rehabilitation. The CDNS and CDANS expertise extends to various other chronic conditions, and they work diligently in collaboration with other health care professionals to provide comprehensive care, education, support, and empowerment to individuals and families living with chronic conditions.

CDNS and CDANS have a multifaceted scope of practice that includes expert assessment and diagnosis. CDNS and CDANS conduct thorough holistic assessments to identify the specific health care needs and challenges of individuals with chronic illnesses. They use their specialized knowledge and expertise to recognize potential complications, evaluate the impact

of the illness on patients' lives, and make accurate diagnoses. Their assessments go beyond physical health to include psychological, social, and environmental factors affecting patients' well-being.

Another important domain of the CDNS and CDANS scope of practice is disease management and treatment. CDNS and CDANS provide specialized care in managing chronic illnesses. They develop and implement evidence-based care plans tailored to the unique needs of each patient. This includes therapeutic interventions such as administering medications and monitoring effects and potential side effects, monitoring disease progression, and coordinating complex treatment regimens. They plan and educate patients and families on self-management strategies, and interventions.

Along the same line, patient education and empowerment are key components of the CDNS and CDANS scope of practice. CDNS and CDANS are instrumental in educating patients and their families about their condition, treatment options, and self-care management, symptom control, and lifestyle modifications to improve overall health and quality of life. They provide comprehensive education on disease processes, therapeutic management, life style modifications, and strategies for coping with the emotional and psychosocial aspects of living with a chronic illness. In addition to empowering patients with knowledge and skills, to support them in taking an active role in their healthcare decision-making and self-management.

CDNS and CDANS collaborate effectively with interdisciplinary healthcare teams to ensure seamless and coordinated care for patients with chronic illnesses. They act as advocates for their patients, facilitating communication among healthcare providers and coordinating the various aspects of care. They work collaboratively to develop comprehensive care plans, ensure continuity of care during transitions and referrals, and integrate community resources and support services to meet the holistic needs of patients.

Through being actively involved in research and evidence-based practice, CDNS and CDANS contribute to the advancement of knowledge and evidence-based practices related to chronic illnesses. They actively engage in research, quality improvement initiatives, and the implementation of best practices within their specialty. By participating in research and staying current with emerging evidence, they enhance the quality of care and contribute to improving outcomes for individuals with chronic illnesses.

CDNS and CDANS provide ongoing support and advocacy for patients and their families. They offer emotional support, referrals, help patients to navigate the healthcare system, and connect them with community resources and support groups. They advocate for policies and

practices that promote the rights, dignity, and well-being of individuals living with chronic illnesses.

In addition to direct patient care, CDANS serve as expert consultants for nursing staff and take an active role in improving health care delivery systems. They often work in management positions and work with a team to develop policies and procedures. The CDANS influence nursing practice outcomes by leading and supporting nurses to provide scientifically grounded, evidence-based care and professional development programs. Implement improvements in the healthcare delivery system and translate high-quality research evidence into clinical practice to improve clinical and fiscal outcomes.

CDNS and CDANS are commonly based in diverse work settings where they can implement their specialized care across various healthcare settings. Their advanced knowledge and expertise in managing and supporting patients with long-term health conditions make them valuable assets in the following work settings: hospitals and medical centers, outpatient clinics, community health centers, home healthcare, palliative care and hospice, and academic and research institutions. Examples of the most common chronic conditions are listed in Appendix A.

Qualifications:

The Chronic Diseases Nurse Specialist (CDNS)

The CDNS is a registered nurse certified to provide specialized chronic care services involved in the care of patients with chronic conditions and their families. The CDNS must hold a minimum educational level of a bachelor's degree in nursing and a higher diploma in chronic care nursing from an accredited university or educational institution listed and recognized by the Jordanian Nursing Council (JNC).

Qualifications:

- Registered with the Jordan Nurses and Midwives Council (JNMC) and is licensed to practice under the Public Health Law.
- Obtained a higher diploma in chronic care nursing from an accredited university or educational institution.
- Passed the exam mandated by JNC according to the provisions of the bylaw on specialization.

The Chronic Diseases Advanced Nurse Specialist (CDANS)

- The CDANS is a registered nurse certified to provide specialized, advanced chronic care services involved in the care of patients with chronic conditions and their families. The CDANS must hold a minimum educational level of a master's degree from an accredited university or educational institution in a field of chronic care specialty listed and recognized by JNC.

Qualifications:

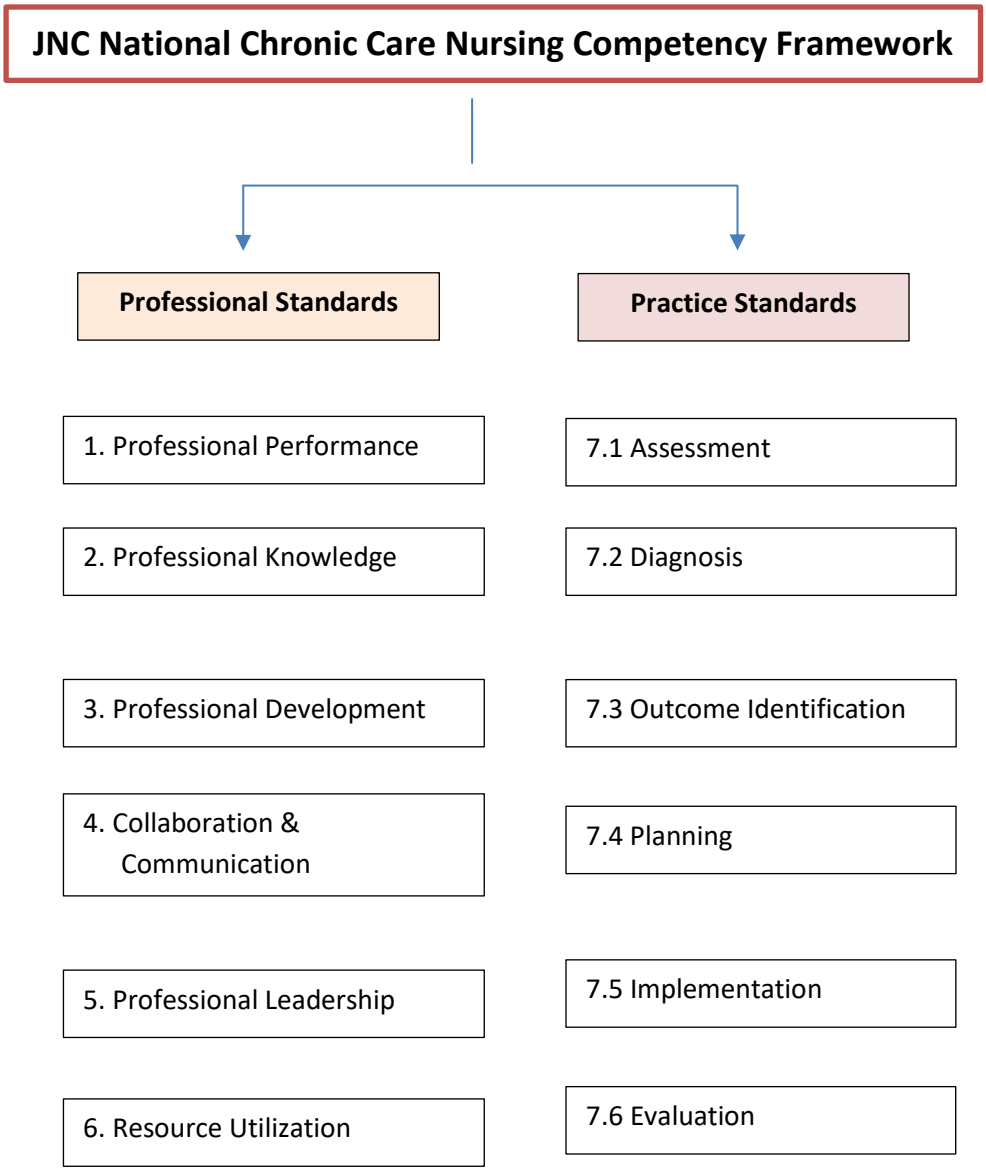
- Obtained a minimum of second university degree (master's degree) from an accredited university or educational institution in a field of specialty listed and recognized by JNC.
- Registered with JNMC and licensed according to the Public Health Law provisions.
- Passed the exam mandated by JNC according to the provisions of the bylaw on specialization.

JNC National Framework for chronic diseases nurse specialist (CDNS) and chronic diseases advanced nurse specialist (CDANS):

The JNC National Framework for CDANS and CDNS is divided into two domains:

1) Professional Standards, and

2) Practice Standards



Section 1: JNC Professional Standards for the CDANS and CDNS:

Standard 1: Professional Performance

While meeting the professional standards of maintaining legal and ethical responsibilities, the CDANS and CDNS are responsible and accountable for, firstly, providing and evaluating quality, safety, and effective management of care for chronic healthcare problems of clients including vulnerable and at-risk populations and their family caregivers. Secondly, plans, coordinates, implements, and evaluates actions to enhance safe and quality healthcare services at an advanced level.

First Core Competency:

The CDANS and CDNS are strongly committed to providing care in a way that respects and preserves the autonomy, dignity, rights, values, beliefs, and preferences of the healthcare consumers and their family members, and to continue to work towards this goal. A CDANS and CDNS mandate is to identify, articulate, and act regarding ethical issues that are facing patients, families, and healthcare providers, as well as, at the system, community, and public policy levels.

Measurement criteria:

- Adheres to the nurses' Code of Ethics as a moral foundation to guide nursing practice and health care decision making.
- Participates in ethical decision making related to own professional obligations, or where ethical issues affect the chronically ill client care or broader health care team.
- Ensures the confidentiality and security of written, verbal, and electronic information acquired during the course of professional activities.
- Respects the dignity and privacy of the client.
- Promotes autonomy and truth-telling among clients and nurses.
- Offers guidance to staff regarding ethical dilemmas and demonstrates expertise in ethical decision-making.
- Ensures that client's rights to information, choice, and self-determination are respected.
- Engages in learning and teaching that addresses ethical risks, benefits, and outcomes.
- Provides end-of-life care to chronically ill clients and their families to ensure their satisfaction and dignity.
- Affirms the legal rights of people and speaks out when these rights are in danger of being violated.

- Respects and accepts cultural traditions, beliefs, and values when planning care for individuals and their families.
- Ensures consent and responds to the needs and wishes of patients and their families.
- Acts professionally and independently in situations where confidentiality may be limited.
- Maintains therapeutic relationships and professional boundaries.
- Advocates for client's rights.
- Investigates unethical nursing practices that impede nursing care.
- Ensures protection of research participant's ethical rights.
- Maintains the confidentiality of all patients during all stages of providing healthcare services.
- Follows the ethical standards and guidelines while utilizing electronic health records.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Manages challenges, behaviors, and practices that may compromise the privacy or dignity of chronically ill clients in a professional way.
- Establishes and maintains a culture of professional ethics.
- Asserts professional integrity, honesty, and ethical conduct in nursing care.
- Assumes an advocacy role to protect human and patients' rights and to question violations of the adult client's rights.
- Provides mentoring and guidance to staff nurses to ensure that safe, competent, and equitable care is provided.
- Consults and educates staff on addressing ethical issues relevant to chronic care.
- Refines ethical competence through continued professional education and personal self-development activities.
- Depicts one's professional nursing identity through demonstrated values and ethics, knowledge, leadership, and professional conduct.
- Represents the nursing perspective in department, clinic, institution, community, or professional association ethics' discussions.

Second Core Competency

Develops and implements quality activities that ensure effective and efficient nursing practice at an advanced level.

Measurement criteria:

- Provides direct care to patients with chronic diseases or conditions.
- Coordinates the care of patients with use of system and community resources to assure successful health/illness/wellness transitions, enhance delivery of care, and achieve optimal client's outcomes.
- Participates in establishing quality improvement agenda for unit, department, program, system, or population.
- Identifies facilitators and addresses barriers that affect client's care outcomes.
- Identifies and develops strategies to enhance quality care and promote safe work environments.
- Ensures that nursing practice is safe, effective, efficient, equitable, timely, and person-centered.
- Uses creativity and innovation to enhance nursing care.
- Documents nursing practice in a manner that supports quality and performance improvement initiatives.
- Synthesizes data and formulates evidence-based recommendations to improve quality care, practice, and healthcare outcomes.
- Implements outcome-focused client care initiatives to improve client self-care to reduce readmissions.
- Develops, incorporates, and evaluates an innovative model of practice across the continuum of chronic care to enhance quality of care.
- Designs and provides health information and patient education appropriate to the client's developmental level, health literacy level, learning needs, readiness to learn, and cultural values and beliefs.
- Develops strategies for scaling successful practices to benefit a broader range of patients and healthcare professionals.
- Implements community-based healthcare programs that meet the diverse healthcare needs of individual patients with chronic illness and their family caregivers.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Provides indirect care (i.e., administration, management, and support services) to clients with chronic diseases.
- Assesses organizational chronic health care for effective delivery system design that directly affects chronic care practice, decision-support, and clinical information systems.
- Analyzes the whole healthcare system and its philosophy to align chronic care accordingly, e.g., the implication of JNC standards for chronic care nursing practice.
- Evaluates the impact of legislative and regulatory policies as apply to nursing practice and patient or population outcomes.
- Articulates the role and significance of the ACCNS in improving healthcare outcomes for chronically ill clients - to other healthcare providers and the public.
- Provides critical review and evaluation of policies, procedures, protocols, and guidelines to improve the quality of health care.
- Engages in formal and informal peer review processes of the inter-professional team.
- Collaborates with the inter-professional team to implement quality improvement plans and interventions.
- Provides leadership in planning data collection and quality monitoring.
- Uses quality monitoring data to assess the quality and effectiveness of clinical programs in meeting outcomes.
- Performs system level assessments to identify variables that influence nursing practice and outcomes.
- Develops indicators and checklists to monitor quality and effectiveness of chronic care nursing practice based on contextual variables, e.g., infection rates, medication and medical errors, falls, pressure ulcers prevalence, readmission rates, morbidity, mortality, adverse events, etc.
- Implements, evaluates, and updates policies, procedures, and/or guidelines to improve the quality and effectiveness of adult nursing practice.
- Leads clinical practice and quality improvement initiatives for chronic care units, clinics, or programs.
- Consults with other nurses and healthcare professionals in managing highly complex client care problems and in achieving quality, cost-effective outcomes for chronically ill patients across healthcare settings.

- Evaluates client outcomes and cost-effectiveness of care to identify needs for practice improvements within the chronic care nursing specialty.
- Develops quality assurance (QA) program that is an ongoing using a systematic process designed to evaluate and promote excellence in the healthcare provided to clients with chronic conditions including Structure (care setting), Process (quality of care provided) and Outcome evaluation focuses on demonstrable changes in the client's health status as a result of nursing care at the level of the unit, ward, or clinic.
- Demonstrates the ability to identify areas for improvement in nursing practice at an advanced level.
- Gathers comprehensive data pertinent to quality indicators regarding the care provided to patients with chronic illnesses.

Third Core Competency

Improves nursing practice to facilitate the physical, psychological, cultural, and environmental measures that promote safety at advanced level.

Measurement criteria:

- Evaluates chronic care nursing practice using safety, timeliness, effectiveness, efficiency, and patient-centered care.
- Demonstrates safe and accountable chronic care nurse specialist practice.
- Initiates and participates in activities that support safe care.
- Promotes safety and risk reduction using evidence-based nursing interventions.
- Promotes safety awareness among staff, clients, and families.
- Plans and implements emergency preparedness and disaster management at the unit level.
- Adheres to nursing national and international safety guidelines.
- Intervenes to prevent and/or minimize complications resulting from chronic diseases or illnesses.
- Fosters an inter-professional approach to safety in practice.
- Facilitates safe and effective transitions of patients across levels of care.
- Reports incidents of unsafe healthcare and/or nursing practice.
- Performs meticulous medical and surgical aseptic techniques and safety precautions while providing nursing care.
- Coordinates infection surveillance at intervals to identify nosocomial and healthcare-

associated infections and resistant organisms in collaboration with other infection control healthcare team specialists.

- Develops strategies that prevent healthcare-associated pressure injuries, clients fall and
  medication errors at the level of the unit.
- Implements strategies to achieve national safety goals at the clinical practice setting.
- Applies the various patient restraints considering safety, prescriptive requirements, and legal implications.
- Engages in professional development activities designed to address patient's safety.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Designs and implements educational programs for staff to create a culture of safe environment.
- Determines nursing practice and system interventions that promote patient, family, and community safety.
- Evaluates client care practices based on research, evidence-based practice and experiential knowledge and integrates changes into practice to improve safety.
- Actively participates in healthcare services research that investigates the effectiveness of well-developed programs to enhance patient's safety.
- Uses data and trends in decision-making to optimize patient safety

Standard 2: Professional Knowledge

CDANS and CDNS exhibit the concepts and principles of chronic care nursing.

First Core Competency

Develops and implements experiential knowledge to provide quality nursing care and promote self-care among chronically ill patients and their families and reduce the costs of the illness and readmissions.

Measurement criteria:

- Demonstrates knowledge of the core concepts, principles, and goals of contemporary chronic care nursing that include Chronic Care Models.
- Addresses the World Health Organization (WHO) “best buy” interventions that moves countries towards chronic diseases mortality reduction targets.
- Demonstrates knowledge of therapeutic interventions including pharmaceutical and non-pharmaceutical chronic care interventions to manage client care
- Demonstrate knowledge in age -specific health education strategies to promote client’s self-care.
- Demonstrate knowledge in strategies that promote self-care, popper identification of early and late signs of deterioration, and decrease readmissions among chronically ill clients.

Second Core Competency

Uses systematic scientific inquiry in clinical practice and quality improvement that involves utilizing research findings, interpreting, and applying evidence, in addition to actively participating in research to optimize adult client outcomes, clinical practice, and cost-effectiveness, as well as to ensure accountability and transparency.

Measurement criteria:

- Identifies issues, research priorities and questions in the health care or practice setting that can be answered by scholarly inquiry.
- Supports and values nurse practice environments that offer opportunities to implement evidence-based practices in adult healthcare.
- Uses research evidence to influence advanced healthcare interventions in chronic care.
- Analyzes and interprets research findings critically.
- Analyzes and evaluate evidence-based healthcare research findings critically and reflectively.
- Assesses current practice based on research findings and identify areas for improvement in chronic care nursing services and practices.

- Integrates evidence-based practice to enhance the quality of care, education, leadership, and management of chronic care.
- Engages in activities that facilitate dissemination of research findings, such as presentations, publications, consultations, and journal clubs.
- Collaborates with other healthcare professionals to conduct and implement research and clinical investigations.
- Collaborates with colleagues to find solutions to issues related to chronic care nursing.
- Uses research findings to make sound, informed clinical decisions relevant to chronic care.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Leads clinical inquiry through quality improvement activities.
- Shares peer-reviewed, evidence-based findings with colleagues to integrate knowledge into nursing practice.
- Reviews nursing research for application in practice and the health care setting.
- Analyzes clinical opportunities and nursing knowledge/practice gaps that may require further research investigation.
- Assess the relevance and appropriateness of various research designs to generate evidence that will serve as a guide for chronic care nursing practice.
- Investigates and analyzes research findings and other evidence to develop innovative interventions, achieve cost-effective results and to determine if changes to practice are required.
- Ensures that patient care practices are evaluated based on research and best practices.
- Ensures and evaluates implementation of evidence-based changes into practice to improve efficiency, reliability, and quality of care.
- Leads the review and development of evidence-based guidelines, protocols, and clinical pathways.
- Develops chronic nursing care policies, procedures, and guidelines based on evidence-based practice knowledge.
- Assists staff with dissemination, implementation, and evaluation of research findings as a role model and mentor.

- Evaluates and facilitates the implementation of newly developed products, techniques, and technologies in clinical settings.
- Benchmarks various chronic care programs by using current evidence-based knowledge, combined with clinical expertise and health care consumer values and preferences, to guide practice in all adult health care settings with evaluative outcome measures.
- Assess and evaluate evidence-based changes using relevant evaluation tools.
- Conducts systematic reviews/meta-analysis, meta-synthesis, or comprehensive reviews to promote system-development and practices of chronic care.
- Generates evidence through scientific research relevant to chronic care nursing.
- Relates current chronic care practices to the best available evidence to reform practice protocols and guidelines or relevant policies and procedures.
- Utilizes research findings to guide the process of policy-change in healthcare settings.

Standard 3: Professional Development

CDNS and CDANS are lifelong learners who are accountable for maintaining competence in clinical practice and engaging in professional development learning activities to enhance advanced knowledge, skills, and clinical judgment in chronic care. The CDNS and CDANS are motivated to acquire and maintain current knowledge and competency in advanced chronic care nursing practice.

First Core Competency

Maintains accountability in the evaluation processes: credentials, privileges, and role performance according to practice standards.

Measurement criteria:

- Engages in self-reflection, performance appraisal, and peer review to ensure competent professional practice and keeps self and staff up to date with current health issues and healthcare trends in the care of patients with chronic illnesses.
- Complies with the credentialing and privileging process within the organization or system.
- Evaluates role performance according to professional practice standards, institutional guidelines, and relevant statutes and regulations.
- Mentors' healthcare providers, students, and others to develop expertise in the care of vulnerable individuals including the frail elderly patient.

- Adheres to all relevant regulatory and licensing board requirements for maintaining credentials and privileges.
- Demonstrates an understanding of personal and team members' roles and responsibilities within the scope of practice as set by the JNC.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Facilitates the provision of clinically competent care by staff/team through education, role modeling, teambuilding, and quality monitoring.
- Plans, coordinates, implements, and evaluates initiative to enhance healthcare providers' competencies and promote current knowledge and expertise in promoting safety of self and clients.
- Demonstrates a commitment to maintaining high standards of care for chronic ill clients through collaboration with other healthcare providers.
- Perform evaluation using institutional evaluation tools to ensure nursing staff competencies and identifying areas of staff development programs

Second Core Competency

Participates in ongoing professional development programs that improve professional performance.

Measurement criteria:

- Engages in educational activities to enhance professional practice of CDNS.
- Uses information gained from educational activities to improve professional performance and competencies.
- Maintains currency and competence in information and patient care interventions appropriate to role of CDNS and CDANS.
- Consciously seeks experiences, formal and independent learning activities to maintain and develop clinical and professional skills and knowledge as well as personal growth.
- Participates in nursing and health professional organization activities.

- Collects and analyze data to monitor the outcomes of care processes and using improvement methods to design and test changes to continuously improve the quality and safety of health care delivery.
- Creates a nursing care environment that stimulates continuous self-learning, reflective practice and demonstration of responsibility and accountability.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Designs, implements, and evaluates staff continuing education programs and activities.
- Mentors chronic care nurses to acquire new skills and develop their nursing practice competencies.
- Promotes career development for students, nurses, and other healthcare providers.
- Contributes to the advancement of the profession by disseminating outcomes of practice through presentations and publications.
- Facilitates the establishment of a culture conducive to professional development within the healthcare system.
- Design, implement and evaluate programs of care and programs of research that address common problems for chronically ill populations

Standard 4: Professional Collaboration and Communication

CDNS and CDANS provide support and/or consultant services to chronically ill clients and families and effectively partners with inter-professional colleagues in the care of chronic conditions to improve client outcomes and quality of care. CDANS also promotes a healthy work environment for the professional development of peers, colleagues, and other professionals.

First Core Competency

Collaborates with nursing staff and interdisciplinary healthcare team at an advanced level by committing to authentic engagement and constructive patient, family, system, and focused problem-solving to provide comprehensive nursing care for chronic conditions.

Measurement criteria:

- Works collaboratively to optimize health outcomes for patients with chronic illnesses.
- Works with individuals of other professions to maintain a climate of mutual respect and
  shared values.
- Collaborates with other care professionals to appropriately assess and address the health care needs of patients and to promote and advance the health of chronically ill clients.
- Communicates efficiently with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health, the prevention and treatment of disease and rehabilitation.
- Applies relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.
- Assists healthcare team members to integrate the needs, preferences, and strengths of the patient into the healthcare plan to optimize health outcomes.
- Establishes collaborative relationships within and across departments that promote patient safety, culturally competent care, and clinical excellence.
- Practices collegially with medical staff and other members of the healthcare team so that all providers' unique contributions to enhance health outcomes are recognized.
- Promotes the role and scope of practice of the CCNS and ACCNS (e.g., to legislators, regulators, other healthcare providers, and the public).
- Facilitates the development of clinical judgment of the healthcare team members through role modeling, teaching, coaching, and/or mentoring.
- Creates and utilizes learning opportunities for orientation and teaching of staff, patients, and families of chronically ill patients.
- Coordinates formal and informal education for healthcare providers to improve chronically ill patients' healthcare outcomes.

- Uses skilled communication to foster true inter- and intra-professional collaboration in the interest of continuity of patient care and professional development.
- Modifies health information, patient education programs, and interventions for patients with sensory, perceptual, cognitive, and physical and mental illness limitations.
- Facilitates access to and use of information and care technology based on assessment of the ability and preferences of patients across the chronic disease trajectory.
- Designs tailored educational programs that enhance the knowledge and skills of chronically ill clients, families, and caregivers regarding home health care, health promotion and prevention activities for chronic care.
- Actively participates in interdisciplinary meetings, rounds, and discussions related to patients with chronic conditions.
- Engages in problem-solving discussions that focus on comprehensive care for patients with chronic conditions.
- Handles conflicts and disagreements within the interdisciplinary team professionally and constructively.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Assists the staff in developing their communication, critical thinking and clinical judgment skills.
- Collaborates with nurses to develop a practice environment that supports shared decision making.
- Provides support, training and/or consultations to other healthcare professionals emphasizing professional collaboration.
- Addresses and manages disruptive behaviors and how they affect the healthcare environment and client safety: such as incivility, bullying, and workplace violence.
- Implements conflict resolution programs within the interdisciplinary team to help team members deal with conflicts professionally and constructively.
- Delegates activities to other healthcare personnel, according to ability, level of preparation, proficiency and scope of practice

Second Core Competency

Facilitates provision of clinically competent care through education, role modeling, team building, and quality monitoring.

Measurement criteria:

- Fosters an inter-professional approach to safety, quality improvement, evidence-based practice, research, and translation of research into practice.
- Uses communication practices that minimize risks associated with patient transfer among providers and across transitions of care.
- Assesses the quality and effectiveness of interdisciplinary, intra-agency, and inter-agency communication and collaboration.
- Facilitates decision-making regarding treatment options with the patient, family, caregivers and/or healthcare providers.
- Establishes collaborative relationships within and across disciplines that promote patient safety, culturally competent care, and clinical excellence.
- Leads and participates in activities such as inter-professional rounds and community health-related activities.
- Monitors patient satisfaction scores and clinical outcomes related to the care provided by nursing staff.
- Tracks improvement initiatives and documents measurable progress overtime.
- Facilitates the adoption of new guidelines and assesses their impact on patient care outcomes.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Leads collaborative efforts of the healthcare team in focusing on individuals and systems issues that impact chronically ill patients t care outcomes.
- Provides consultation, counseling and support to staff nurses, medical staff, and interdisciplinary colleagues.
- Mentors' healthcare team members to understand, appreciate and use the expertise of other professionals to enhance health care outcomes of chronically ill patients.
- Develops and implements educational programs that enhance the clinical competence of nursing staff.
- Ensures that nursing staff are updated on the latest clinical guidelines and evidence-based practices.

- Measures team cohesion through feedback surveys or assessments of communication and collaboration among team members.
- Develops and implements competency assessment tools that objectively evaluate the clinical skills and knowledge of nursing staff.
- Advocates for and implements policies and strategies from a systems perspective to establish positive practice environments, including the use of best practices in recruiting, retaining and developing human resources**.**

Third Core Competency

CDNS and CDANS advocate and support for their chronically ill clients (e.g., individuals, families, communities, or populations) by protecting their rights and voicing their needs based on respect for their preferences, values and beliefs and background.

Measurement criteria:

- Champions the needs, rights and voice of the health care consumer.
- Recommends appropriate levels of care, timely and appropriate transitions, and allocation of resources to optimize healthcare outcomes.
- Promotes safe care of health care consumers, safe work environments, and sufficient resources.
- Participates in health care initiatives on behalf of the health care consumer and the system(s) where nursing care is involved
- Demonstrates a willingness to address persistent, pervasive nursing care issues.
- Orientate the political decision-makers about the role of nurses and the vital components necessary for nurses and nursing to provide optimal care delivery.
- Empowers all members of the health care team to include the health care consumer in care decisions, including limitation of treatment and end-of-life care.
- Embraces diversity, equity, inclusivity, health promotion, and health care for individuals of diverse geographic, cultural, ethnic, racial, gender, and spiritual backgrounds across the life span.
- Role models advocacy behavior.
- Addresses the urgent need for a diverse and inclusive workforce as a strategy to improve outcomes related to the social determinants of health and inequities in the health care system.
- Contributes to professional organizations.

- Acts as a vocal advocate for clients' perspectives within healthcare settings and interdisciplinary teams.
- Demonstrates use of effective communication that reflects a comprehensive understanding of clients' unique situations.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Develops policies that improve care delivery and access for underserved and vulnerable populations.
- Promotes policies, regulations, and legislation at the local, and national levels to improve health care access and delivery of health care.
- Considers societal, political, economic, and cultural factors to address social determinants of health.
- Advances policies, programs, and practices within the health care environment that maintain, sustain, and restore the environment and natural world.
- Identifies challenges faced by chronically ill clients and proactively seeks viable solutions.
- Gathers feedback from clients about their satisfaction with the advocacy and support received.
- Uses health care consumers feedback to improve advocacy strategies and measure the impact of provided support.

Standard 5: Professional Leadership

CDNS and CDANS roles include leadership, management, delegation, and change. CDNS and CDANS serve as a leader of multidisciplinary team in designing and implementing alternative solutions to chronic care issues across the continuum of care and manages change and leads others to influence practice and political processes within and across systems. CDNS and CDANS as managers have the authority, power, and responsibility for planning, organizing, coordinating, and directing the work of others and for establishing and evaluating standards.

Core Competency

Exhibit's ability to establish direction, influence and motivate others to achieve their maximum potential to accomplish clinical tasks, objectives, or projects within and across systems.

Measurement criteria:

- Utilizes effective leadership skills to achieve quality outcomes and a culture of safety.
- Leads decision-making groups and micro/macro system-level change.
- Engages in creating an inter-professional environment that promotes respect, trust, and integrity.
- Embraces practice innovations and role performance to achieve lifelong personal and professional goals.
- Facilitates creation of a common/shared vision for care within the healthcare team and system.
- Communicates effectively to lead change, influence others, and resolve conflict.
- Supervises implementation of evidence-based practices for safe, quality health care and health care consumer satisfaction.
- Demonstrates authority, ownership, accountability, and responsibility for appropriate delegation of nursing care.
- Mentors' colleagues and others to embrace their knowledge, skills, and abilities.
- Participates in professional activities and organizations for professional growth and influence.
- Advocates for chronically ill clients, family members, communities, the nursing profession, legislation and environmental health in practice and policy that promote health and improve care delivery.
- Demonstrates leadership skills in implementing innovation and evidence-based practices.
- Inspires, energizes, and empowers team members and acts as a role model for professional leadership and accountability for nursing roles within the healthcare team and community.
- Ensures adequate coverage of all shifts with appropriately qualified healthcare providers and skills mix in accordance with the organizational policies, guidelines, and norms.
- Manages the home health care visits to ensure quality, safe effective and efficient multidisciplinary health care.

- Ensures follow up care are customized to patient needs, varies in intensity and methodology (phone, in person, email).
- Safeguards a clients' registry that is tied to guidelines which provide prompts and reminders about needed services.
- Interprets and facilitates integration of organizational mission, goals, and systems into chronic care practices.
- Demonstrates the ability to influence team members, peers, and stakeholders positively.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Engages in commissioning chronic care departments/clinics with confidence based on sound knowledge of the needs and resource requirements of chronic care departments/clinics.
- Ensures clearly defined roles including patient self-management education, proactive follow-up, and resource coordination and other skills in chronic illness care.
- Develops team members to their highest potential by motivating chronic care professionals to perform beyond expectations by:
    1. Creating a sense of ownership in reaching a shared vision.
    2. Convening a sense of loyalty through shared goals, resulting in increased productivity, improved morale, and increased employees' job satisfaction.
    3. Inspiring them to promote team and organizational interests.
- Updates clinical protocols to meet contemporary healthcare needs of patients with chronic diseases.
- Demonstrates knowledge and proficiency in acting as a change agent at all times especially during the emergence of unpredictable health emergencies.
- Performs ongoing and careful assessment of the actual needs and conditions of the chronically ill client's population and the potential risks or harm and identify issues requiring policy, cultural or societal changes.

Standard 6: Resource Utilization

CDNS and CDANS promote effective resource utilization in order to promote safe, quality, responsible and cost-effective client care.

Core Competency

Effectively utilize resources, facilities, and materials to plan, provide, and promote nursing care interventions that are safe, effective, financially responsible, and used judiciously.

Measurement criteria:

- Partners with the chronically ill clients, healthcare professionals and other stakeholders to identify nursing care needs and necessary resources to achieve desired outcomes.
- Collaborates with chronically ill clients, healthcare professionals and other stakeholders to assess costs, availability, risks, and benefits in decisions making about nursing care.
- Secures appropriate resources to address needs of chronically ill clients across the health care continuum on a daily/regular basis.
- Advocates for equitable resources that support and enhance nursing practices and health outcomes.
- Integrates related health care technologies into nursing care practice to promote positive interactions between chronically ill clients and health care providers.
- Uses organizational and community resources to implement inter-professional plans.
- Addresses discriminatory health care practices and the adverse impact on allocation of resources.
- Considers fiscal and budgetary implications in decision-making regarding practice and system modifications.
- Assists healthcare professionals and other stakeholders in developing innovative and cost-effective programs or protocols of care.
- Evaluates impact of introduction or withdrawal of products, services, and technologies to nursing care and practices.
- Acts as a role model and mentors in employing innovative strategies for effective resource use among the healthcare team.
- Assesses, facilitates, and advocates the impact of social, political, regulatory, and

economic forces on delivery of care.

- Evaluates the use of products and services for appropriateness and cost-benefit in meeting chronically ill patients nursing care needs.
- Empowers patients with chronic diseases to design and implement appropriate health-related plans of care using available resources.
- Acknowledges the role of family and social support in effective use of resources in promoting self-care for patients with chronic health conditions.
- Provides cost-effective pharmacological and non-pharmacological interventions that meet the healthcare needs for patients with chronic diseases.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned.

- Develops strategies that lead to facilitating transition of patients through the healthcare system with efficient minimum cost.
- Designs evaluation strategies to demonstrate cost-effectiveness, cost-benefit, and efficiency (fitness for purpose) factors associated with chronic illnesses nursing care practices.
- Conducts cost-benefit analysis of new clinical services and technology.
- Evaluates the benefits and cost-effectiveness of different healthcare programs and interventions.
- Effectively allocates resources (time, personnel, tools) to ensure successful project execution.
- Investigates the usefulness and effectiveness of available complementary and alternative therapies to optimize the health outcomes of patients with chronic health conditions.

Section II: The JNC National Practice Standards for CDNS and CDANS

Standard 7: Practice Standards

7.1 Assessment

The assessment process is essential to establishing a nursing diagnosis, developing a plan of care and predicting the outcome of chronically ill clients. It is the responsibility of the CDNS and CDANS to collect comprehensive, systematic, accurate data and prioritized nursing assessments pertinent to the issue, situation, or trend that needs to be addressed. Accurate and validated data enhances the capacity of chronic care nurses to make a sound clinical judgment regarding appropriate treatments and nursing interventions. The collection of data should be based on the client's immediate, short-term, and long-term health conditions or needs.

Core Competency

Uses standardized assessment instruments (Diagnostic process, clinical reasoning, clinical judgment, and decision-making) to collect, organize, interpret, analyze, and synthesize data from multiple sources to identify significant cues essential to formulate nursing diagnoses and determine a care plan.

Measurement criteria:

- Gathers pertinent data about the chronically ill client regarding:
    1. Functional abilities and cues relevant to Nursing Interventions Classification (NIC) Taxonomy.
    2. Physical, psychological, social, cognitive, cultural, and spiritual status.
    3. Ethical, environmental (safety, support systems, etc.), economic, legal (advance directives, DNR)
    4. History of health patterns and illness(es).
    5. Health beliefs and practices.
    6. Client’s perception of health status and health goals.
    7. Trajectory of chronic disease
    8. Strengths and competencies that can be used to promote health.
    9. Knowledge of and accessibility to health care and healthy lifestyle behaviors.
    10. Developmental status, including family life cycle phase and roles.
    11. Sources of emotional, social, spiritual, and financial support.
    12. Other contributing factors that influence health.

- Obtains accurate and relevant objective and subjective information through systematic health and nursing assessments.
- Demonstrates competency in a range of physical assessment and diagnostic skills, using appropriate techniques and technology, to assess the health care needs of chronically ill clients.
- Demonstrates competency in chronically ill client health assessment interview.
- Demonstrates a thorough understanding of techniques, tools, guidelines, laboratory investigations, and methods necessary to obtain comprehensive information regarding the patient's condition to formulate a diagnosis.
- Collects data using appropriate evidence-based assessment parameters and techniques.
- Integrates and interprets data from a variety of sources, including interviews, physical examinations, psychosocial assessments, laboratory, and radiology investigations, as well as diagnostic procedures.
- Utilizes evidence-based assessment frameworks to collect data on a variety of health domains.
- Complies with professional standards and organizational policies when sharing and documenting findings.
- Provides systematic, ongoing, and accurate means of collecting and validating pertinent data.
- Synthesizes, prioritizes and summarizes relevant data based on assessment data as well as client needs and desires.
- Collaborates with clients and other healthcare providers in the ongoing collection and update of assessment data.
- Ensures that data reflects clients' personal beliefs, culture, ethnicity, age, gender, values, and life experiences.
- Conducts assessments at inter and intra system level to determine which variables affect chronically ill client outcomes and nursing practice
- Interprets data collected to gain an understanding of the adult client's capacity and health needs.
- Documents relevant data accurately in a patient file in a clear and systematic manner.
- Demonstrates competency in using a written (or electronic) format that organizes the assessment data systematically.
- Reviews assessment practices to identify gaps in translation of evidence into practice.

- Ensures that a language interpreter is used if necessary to ensure that the data collection is accurate.
- Collects data that reflect sensitivity to cultural diversity, ethnicity, gender, and lifestyle choices from multiple sources, including chronically ill clients, families, significant others(s), health care providers, medical records, and community health statistics (epidemiological studies on community health, community needs assessments, etc.).
- Validates assessment data.
- Ensures accuracy of all information while communicating (both verbally and in writing) with patients with chronic health conditions, their family members, and healthcare providers.
- Effectively disseminates health information during team meetings, hand-off reporting, and patients' follow-up.
- Abides with internationally approved and used standards of healthcare information documentation.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Examines the impact of multiple variables (e.g., among the individual client, community, hospital, and social systems) on health and illness.
- Assess potential risks to chronically ill clients' safety, autonomy, and quality of care.
- Uses evidence-based and best practice guidelines in improving the assessment process.
- Ensures self and colleagues' competencies in assessing while participating in self and peer-reviews and evaluation to assess needs for continuing education.
- Provides ongoing professional development training programs to ensure that other nurses and healthcare providers are capable of conducting thorough, timely assessment for chronically ill patients.

7.2 Diagnosis

The nursing diagnosis is the nurse's clinical judgment about the chronically ill client's response to actual or potential health conditions or needs. The nursing diagnoses are based on the analysis and interpretation of data about the chronically ill client's needs, problems, age, as well as their health status. Nursing diagnoses describe a continuum of health states: deviations from health, presence of risk factors and areas of enhanced personal growth. It is imperative to use institutional standard systems of nursing diagnosis classification, such as the North American Nursing Diagnosis Association (NANDA) classification system, to ensure conformity in communication and documentation within the nursing field.

Core Competency

CDNS and CDANS use critical thinking skills to interpret, analyze and synthesize the assessment data, identify actual and potential health problems, and uses these findings as the basis for developing nursing diagnoses that can be used to design interventions aimed at promoting, restoring, and maintaining health.

Measurement criteria for CDNS:

- Analyzes assessment data to identify client’s health problems, risks and strengths.
- Synthesize data from relevant sources to formulate a differential diagnosis of clinical conditions based on the data.
- Identifies client’s health problems, risks and strengths.
- Utilizes clinical judgment in determining the diagnostic label that is appropriate for the chronically ill client problems and/or needs.
- Formulates a nursing diagnostic statement according to NANDA's taxonomy to support the diagnosis.
- Acknowledges the different types of nursing diagnoses are relevant to the Nursing Diagnosis System (such as well-being, risk, and actual health).
- Validates nursing diagnoses with the chronically ill client, their family, significant other(s), and other health care professionals involved in the client's care.
- Collaborates with chronically ill clients, families, and other disciplines to prioritize a diagnosis based on their symptoms and needs.
- Documents the Nursing diagnoses in a way that facilitates communication and evaluation of the client's expected outcome
- Revises Nursing diagnoses frequently if new or additional assessment data is available that can be used to make further adjustments.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Evaluates the quality of nursing staff competency in the diagnostic process.
- Monitors and consults nurses on enhancing their diagnostic skills such as clinical reasoning and decision-making skills.
- Engages in scholarly activities to define and identify emerging nursing diagnoses.
- Implements routine workshops to raise the awareness of nursing staff regarding the updates of NANDA.

7.3 Outcome Identification

A nursing-sensitive client outcome is an individual, family, or community state, behavior, or perception that is measured along a continuum in response to a nursing intervention(s). The CDNS recognizes the expected outcomes for the patient based on assessment data and nursing diagnosis. The CDNS work together with the health care consumer, inter-professional team, and others to identify expected outcomes integrating the health care consumer's culture, values, and ethical considerations. Expected outcomes are documented as measurable goals with a time frame for attainment.

Core Competency

Identifies and formulates observable and measurable expected outcomes for the individualized care plan.

Measurement criteria:

- Describes the outcomes indicators based on assessments and diagnoses accurately.
- Collaborates with chronically ill clients and family, and other health care providers to identify expected outcomes that are consistent with the client's present and potential capabilities, as well as his or her values, culture, and environment.
- Considers associated risks, benefits, current evidence, clinical expertise, resources and cost when formulating expected outcomes.
- Identifies and analyses factors that enhance or hinder the achievement of desired outcomes.
- Modifies expected outcomes based on changes in patient condition or situation.
- Documents outcomes as measurable long- and short-term goals in patient file in clear and systematic manner.

- Establishes specific indicators of progress in achieving expected outcomes.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Monitors and consults nurses on establishing observable and measurable outcomes.
- Identifies and prioritizes clinical and systems' problems using education, evidence, expertise, and experiential knowledge.
- Provides timely feedback to other nurses regarding the accuracy and appropriateness of formulated outcomes.

7.4 Planning

In planning, the CDNS and CDANS refer to chronically ill client's assessment data and diagnostic statements for direction in formulating client goals and designing the nursing interventions required to prevent, reduce, or eliminate the client's health problem.

The CDNS and CDANS develop and facilitate the plan that prescribes interventions to attain expected outcomes within the three areas of influence: the patient and family, nursing, and organizations.

Core Competency:

Plans patient-centered care interventions in collaboration with other healthcare team members to achieve the goals and expected outcomes.

Measurement criteria:

- Determines when evidence-based guidelines, policies, procedures, and plans of care need to be tailored to the patient and family.
- Designs evidence-based nursing interventions to meet the comprehensive needs of chronically ill patients/populations (e.g., safety, quality, and cost).
- Tailor standardized care plans to meet the individualized needs of the client
- Communicates with nursing staff and other health care team members to determine the best strategies to achieve expected outcomes.
- Designs or selects health information and client education appropriate to develop and improve healthcare outcomes.
- Develops, implements, and modifies plans of care or system initiatives within the spheres of influence, patient, nursing, and organization.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Applies critical thinking and clinical judgment underpinned by scientific, biomedical, and technological knowledge in the chronic care field to deduce a plan of care for the client.
- Develops a complex, comprehensive, standardized, and evidence-based plan of care according to determined healthcare priorities and care management tools in collaboration with the relevant multidisciplinary team.
- Formulates collaboratively an ongoing critical analysis of the plan of care based on the chronically ill patient progresses and as directed by the care management tools (e.g. protocols, algorithms, and guidelines) and laboratory findings.
- Reviews and revises the chronically ill patient's plan of care collaboratively according to the compromise/ deterioration or progress of the patient as illustrated/confirmed in the patient status, advanced technological parameters, and laboratory finding.

7.5 Implementation

Implementation is the action phase in which the CDNS and CDANS perform the nursing interventions within the three areas of influence: the patient, nursing, and organizations. The nurse performs or assigns the nursing activities for the interventions that were developed in the planning step and then concludes the implementing step by recording nursing activities and the resulting client responses.

Core Competency:

Provides comprehensive, safe, and effective evidence-based and patient-centered care to achieve identified health outcomes.

Measurement criteria:

- Provides direct care to chronically ill patients based on the needs of patients and specialized knowledge and skills.
- Reassess the chronically ill client to ensure interventions are still needed.

- Prioritize the nursing diagnosis to be managed based on the urgency, client's preference or other health care team plans
- Implements dependent and independent nursing interventions to achieve the desired outcome.
- Documents patient's responses to nursing activities accurately
- Implements pharmacologic and non-pharmacological interventions, diagnostic measures, monitoring durable medical equipment, procedures, and treatments as identified in the plan of care.
- Coordinates and delegates implementation of an individualized plan of care collaboratively with patients, families and the healthcare team.
- Uses behavioral, communication, and environmental modification strategies with patients who have cognitive and/or psychiatric impairments.
- Documents implementation activities including consultations, assessments,
- recommendations, interventions, and evaluations in the patient's record.
- Provides consultation and initiates appropriate referrals of chronically ill client as needed.
- Implements evidence-based clinical guidelines, care paths, policies and procedures, and tailors them to specific populations to facilitate self-care and prevent symptoms' exacerbation.
- Coordinates services to optimize transitions of care.
- Implements treatments and nursing intervention in safe, effective and ethical manner.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Implements strategies using evidence-base and online guidelines to identify and/or manage age-related syndromes.
- Facilitates learning among patients, staff, other disciplines, and organizational leaders.
- Leads system change to promote health outcomes, system efficiency, and a healthy work environment through evidence-based practice.
- Implements individualized, comprehensive, and evidence-based care based on the findings of the scientific, biomedical, and technological assessment of the chronically ill patient within the relevant contextual variables/factors and multidisciplinary collaboration to prevent readmissions.

- Supervises, leads, manages, and administers appropriate care to chronically ill patients on technological support.
- Evaluate healthcare services provided to chronically ill patients.
- Analyzes data to inform the stakeholders and policy makers about the need to adjust and optimize healthcare services.

7.6 Evaluation

Evaluating is a planned, ongoing, purposeful activity in which chronically ill clients and healthcare professionals determine the client's progress toward achievement of goals or outcomes and the effectiveness of the nursing care plan. The CDNS and CDANS evaluate and communicate progress toward attainment of expected outcomes within the three spheres of influence: the patient, nursing, and organizations/systems. On the basis of this evaluation, the plan of care is either continued, modified, or terminated.

Core Competency

Determines progress of patient and groups towards achieving planned desired outcomes and the effectiveness of the nursing care to ensure care is patient-centered, safe, timely, effective, efficient, and equitable.

Measurement criteria:

- Revises diagnoses, expected outcomes, and interventions based on information gained in the evaluation process.
- Bases the evaluation process on advanced knowledge, evidence, expertise, quality indicators, benchmarking, and research.
- Collect data to assess the achievement of the clients care desired outcomes
- Interpret and analyze date to arrive to a decision regarding the achievements of clients care desired outcomes
- Utilizes evaluation data to modify the plan of chronic care of the patient with life threatening condition in accordance with protocols and algorithms and in collaboration with the multidisciplinary team.
- Performs follow-up evaluation to ensure the continuity of care provided to chronically ill patients.
- Measures health outcomes and chronically ill patients' behaviors to evaluate the effectiveness of nursing plans of care and interventions.

- Evaluates any facilitators and\or barriers of achieving the desired outcomes experienced by the chronically ill patients.

Additional measurement criteria for CDANS:

CDANS must also meet the following criteria in addition to those previously mentioned:

- Evaluates impact of interventions and nursing practice changes on systems of care using nurse-sensitive outcomes.
- Evaluates and modifies the overall quality of care given to groups of chronically ill clients (in hospital unit, ward, or clinic).
- Evaluates the effectiveness of practice on healthcare outcomes within the three spheres.
- Evaluates impact of legislative and regulatory polices as they apply to nursing practice and patient or population outcomes.
- Monitors and critically evaluates on a regular basis the progress of the patient with a life-threatening condition against the collaboratively predetermined and revised outcomes of the chronically ill patient.
- Evaluates evidence-based algorithms, clinical guidelines, protocols, and care paths for appropriateness to patient population.
- Evaluates all three spheres to ensure care is patient-centered, safe, timely, effective, efficient, and equitable.
- Evaluates the clinical practice and performance of healthcare team members (e.g., nursing staff, medical staff, and other healthcare providers)

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Appendix A

Examples of Chronic Diseases

Please note that this list is not exhaustive of chronic diseases.

Cardiovascular System:

- Coronary artery disease
- Atherosclerosis
- Heart failure
- Cardiac dysrhythmias
- Cardiomyopathy
- Venous Thrombosis (Deep Vein Thrombosis - DVT)
- Peripheral Vascular Disease (PVD)

Respiratory System:

- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Obstructive Sleep Apnea (OSA)
- Pulmonary Hypertension
- Bronchiectasis

Endocrine System:

- Diabetes (Type 1 and Type 2)
- Hypothyroidism
- Hyperthyroidism
- Addison's Disease
- Cushing's Syndrome
- Acromegaly
- Hyperparathyroidism
- Hypoparathyroidism

Musculoskeletal System:

- Osteoporosis
- Gout
- Osteoarthritis
- Osteomyelitis
- Paget's Disease of Bone
- Carpal Tunnel Syndrome
- Herniated Disc (Slipped Disc)
- Low back pain

Nervous System:

- Stroke
- Headaches
- Multiple Sclerosis (MS)
- Epilepsy
- Alzheimer's Disease
- Parkinson's Disease
- Peripheral Neuropathy
- Amyotrophic Lateral Sclerosis (ALS)
- Huntington's Disease
- Myasthenia Gravis
- Trigeminal Neuralgia
- Bell's Palsy
- Guillain-Barré Syndrome
- Traumatic Brain Injury (TBI)
- Spinal Cord Injury (SCI)

Gastrointestinal System:

- Gastroesophageal Reflux Disease (GERD)
- Irritable Bowel Syndrome (IBS)
- Peptic Ulcer Disease (PUD)
- Inflammatory Bowel Disease (IBD) - Crohn's Disease and Ulcerative Colitis
- Diverticulitis

- Constipation
- Diarrhea
- Gastritis
- Gastrointestinal Bleeding
- Hemorrhoids
- Chronic Cholecystitis
- Chronic Pancreatitis

Immune System:

- Systemic Lupus Erythematosus (SLE)
- Psoriasis
- Rheumatoid Arthritis
- Inflammatory Myopathies (Dermatomyositis, Polymyositis)
- Pernicious Anemia

Reproductive System:

- Benign prostate hyperplasia
- Prostatitis
- Pelvic Inflammatory Disease (PID)
- Ovarian Cysts

Metabolic System:

- Metabolic Syndrome
- Hyperlipidemia
- Obesity
- Acid-base imbalances

Hematological System:

- Anemia
- Hemophilia
- Thalassemia
- Sickle Cell Disease
- Idiopathic Thrombocytopenic Purpura (ITP)
- Polycythemia Vera
- Chronic Myeloid Leukemia (CML)

Integumentary system:

- Burns

- Eczema
- Vitiligo
- Psoriasis
- Pressure/decubitus ulcers

Urinary System:

- Chronic Bladder Infections (Recurrent Urinary Tract Infections)
- Chronic Kidney Stones
- Chronic Kidney Disease (CKD)
- Dysfunctional voiding disorders
- Glomerulonephritis
- Nephrotic syndrome
- Nephritic syndrome

Other/General:

- Hepatitis
- Cirrhosis of the Liver
- Liver Fibrosis
- Hepatic Encephalopathy
- Allergic Rhinitis
- Food Allergies
- Chronic Hives (Urticaria)