Care Transitions

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You might have heard the term "care transitions" and wondered what it means. A care transition refers to the movement of patients from one healthcare provider or setting to another (Healthcare.gov, 2011). Care transitions can occur all along the healthcare continuum and could include a patient moving from a primary care to a specialty physician; in the hospital it would be patients moving from the emergency room to other departments; or when patients are discharged from the hospital and go home or to a nursing home or assisted living facility. During these transitions, patients with complex healthcare needs are vulnerable and errors can occur. Good communication and coordination among healthcare professionals between settings are factors that can improve patient outcomes (Craig C, Eby D, Whittington J., 2011).

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 (Care Transition Program, 2011). The United States Department of Health and Human Services is working together with other agencies to help healthcare providers develop effective programs to improve care transitions (USDHHS, 2011). The focus of these programs includes decreasing re-hospitalization rates for patients with complex medical problems; medication reconciliation, or making sure the patients medication list is up to date and accurate; and improving communication among healthcare professionals between care settings.

The VNA of Manchester and Southern NH has a team of Registered Nurses who are expert at providing transitional care for patients who are discharged home from different healthcare settings. Once a referral has been made for home health services, they meet with patients and families in the hospital or nursing home setting and coordinate and communicate patients' care needs between the transferring and receiving provider. The VNA transition nurses work closely with the social workers and case managers in hospitals and nursing homes in the greater Manchester and southern New Hampshire area and their role is vital to ensuring successful care transitions for patients. If you or your loved ones need home health services, be sure to ask your provider about making arrangements to have the VNA of Manchester and Southern New Hampshire take care of you. The VNA transition nurse can come and meet with you to discuss your care if needed. It can make the all the difference for a successful transition home.

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