

Care Coordination and Transition Management Definitions

Care Coordination - Agency for Healthcare Research and Quality (AHRQ) 2011

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 marshalling 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.

Care Coordination - National Quality Forum (NQF) 2010

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.

Transitional Care – Naylor, Aiken, Kurtsman, Olds, & Hirschman 2011

Transitional Care is broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes and timely transfer of patients from one level of care to another or from one type of setting to another.

Care Transitions – Coleman & Boulton 2003

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.

Transitional Care - Coleman & Boulton 2003

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.

Transition Management – Haas, Swan, & Haynes 2014

Transition management is the ongoing support of patients 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 patients' and/or families' needs for support for ongoing, longitudinal individualized plans of care and follow-up plans of care within the context of health care delivery.

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

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

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

