4.08 HANDOFFS AND TRANSITIONS OF CARE

Introduction

Transitions of care are patient-centered events. They therefore describe when a patient moves from one level of care to another, from one institution to another, or from one system to another as occurs with pediatric to adult care transitions. One component of transitions of care is the patient handoff, which is a provider-centered event that also occurs outside of a patient transition, such as during shift change. Handoffs refer to the interaction between providers when responsibility for patient care is transferred from one provider to another. Ineffective transitions of care and handoffs jeopardize patient safety and may result in adverse events, increased healthcare utilization, and stress for patients or the family/caregivers. Thus, every transition of care and handoff should involve a set of actions designed to ensure that the transfer is safe, efficient, and effective. Pediatric hospitalists routinely utilize handoffs in daily work, are integral in patient transitions of care, and should be competent in both.

Knowledge

Pediatric hospitalists should be able to:

- Compare and contrast patient handoffs with transitions of care.
- Discuss the critical elements that should be communicated between providers at the time of a patient handoff and how these elements may vary depending on characteristics of the patient or the provider.
- Discuss the value of using available handoff aides such as communication patient safety acronyms, handoff tools, and checklists.
- Describe the benefits and risks of automated electronic medical record data integration into handoff aides.
- Discuss the value of using available discharge toolkits to integrate processes, checklists, education, and assessment of quality outcome metrics related to discharge transition of care.
- Compare and contrast the value of potential discharge transition of care metrics, such as patient experience, unplanned returns for care, post discharge planned visit adherence, retained understanding of medication and treatment plans, and others.
- List the relevant information that should be communicated during each transition of care to ensure patient safety and promote the continuum of care.
- Explain the benefits and risks of different modes of communication in the context of the various types of patient transfers.
- Differentiate between the available levels of care and determine the most appropriate option for each patient.
- Describe the impact of the Emergency Medical Treatment and Active Labor Act (EMTALA) on patient transfers.
- Summarize the care commonly available for children at post-acute care facilities, such as rehabilitation facilities.
- Review the steps needed to ensure safe hospital discharge transition of care for patients who will receive home care services, including collaborating with discharge planning staff, placing appropriate orders, securing a post-discharge responsible provider, and other steps.
- Discuss elements important to the safe transition of care at hospital discharge for the patient and family/caregivers, including use of teach-back, handouts, and other tools for patient and family/caregivers' engagement and empowerment in care planning for the home environment.
- Cite the benefits of and barriers to ongoing discharge transition of care education from the time of admission for patients and the family/caregivers.
- Summarize the approach toward initiating transition of care discussions with the family/caregivers of adolescent patients with chronic conditions, attending to patient age, developmental status, empowerment, healthcare system barriers, and others within the local context.

Skills

Pediatric hospitalists should be able to:

- Prepare concise clinical summaries in preparation for patient handoffs or transitions of care, incorporating key elements as appropriate.
- Standardize handoffs to ensure accuracy and concise and complete transfer of information.
- Demonstrate skills in utilizing local handoff tools, acronyms, and checklists.
- Educate trainees on proper handoff communications.
- Utilize the most efficient and reliable mode of communication for each transition of care.
- Arrange safe and efficient transfers to, from, and within the hospital setting.
- Review the medical information received from referring providers and clarify any discrepancies when accepting a new patient.
- Anticipate needs prior to the time of discharge to begin discharge planning early in the hospitalization.
- Provide clear discharge instructions that consider the primary language and reading level of patients and the family/caregivers and include key components (such as diagnosis specific instructions, contingency plan, medications, follow up recommendations/appointments, information about available resources, and others).
- Communicate effectively with the primary care and other providers as necessary at the time of admission, discharge, and other transitions of care.
- Select and order appropriate post-acute care facilities and services within the local context.
- Accurately and completely reconcile medications during transitions of care.
- Coordinate care that ensures the future comprehensive review of patient data that was pending at the time of discharge.

Attitudes

Pediatric hospitalists should be able to:

- Recognize the impact of ineffective handoffs and transitions

of care on patient safety and quality of care.
- Demonstrate respect for referring physicians and seek their input when developing protocols for communication during transitions of care.
- Recognize the impact of the transfer on patients and the family/caregivers and the importance of ensuring their goals and preferences are incorporated into the care plan at all stages of the transition of care.
- Exemplify responsible coordination of a multidisciplinary approach to patient and the family/caregiver education in preparation for the transition of care.
- Realize the need to provide support for patients, the family/caregivers, and healthcare providers after transitions of care should questions arise.

Systems Organization and Improvement

In order to improve efficiency and quality within their organizations, pediatric hospitalists should:

- Lead, coordinate, or participate with key stakeholders in the ongoing evaluation and improvement of the referral, admission, and discharge processes.
- Lead, coordinate, or participate in initiatives to develop and implement systems that promote timely and effective communication between providers during handoffs and transitions of care.
- Collaborate with hospital administration and community partners to develop and sustain referral networks between local facilities and referral centers for hospitalized patients and for those transitioning to adult healthcare systems.

References

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